County of Los Angeles - Department of Mental Health
Housing and Job Development Division
Federal Housing Subsidies Unit

HACLA CONTINUUM OF CARE APPLICATION COVERSHEET & CHECKLIST - (rev. 08/11/21)

The following forms are **required for every applicant** under the Continuum of Care (CoC) Program. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, **please complete all forms thoroughly**. Place a check mark next to those documents included in this application packet and arrange forms in the following order:

_____ **1.** HACLA Continuum of Care Application Coversheet and Checklist
_____ **2.** Housing Intake and Needs Assessment, ***3 pages***
_____ **3.** HMIS Intake and Enrollment Form, ***11 pages*** *to be completed for **each adult and minor** in the household*
_____ **4.** Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 HMIS), 2 pages***
_____ **5.** Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 HACLA), 2 pages***
_____ **6.** Service Provider Responsibility Form, ***2 pages***
_____ **7.** Continuum of Care Client Agreement
_____ **8**. Affordable Care Act Certification Form
_____ **9**. McKinney Vento Act Notice - Acknowledgement of Receipt
_____ **10.** Agency Referral Letter – including a 3-year timeline of housing / homelessness history
(Include explanation of address on ID if different from current address & why client can't return there.)

HACLA CONTINUUM OF CARE INSERT

_____ **11.** HACLA CoC Application Coversheet and Checklist Transmittal Form, ***2 pages***
_____ **12.** Referral Transmittal Form
_____ **13.** CES Referral Form, *completed by CES Matchers for applicants prioritized though CES **only***
_____ **14.** Special Programs Application for Rental Assistance, ***11 pages*** This form is not on the web, contact FHSU
_____ **15.** Authorization for Release of Information, ***2 pages*** *signed by **all** adults*
_____ **16.** Authorization to Release of Information to DMH - *signed by **all** adults*
_____ **17.** Authorization for the Release of Information/Privacy Act Notice ***(form HUD-9886), 2 pages***
_____ **18.** Declaration of Citizenship/Eligible Immigration Status ***(forms NC-100A & NC-101), 2 pages***
_____ **19.** Certification of No Conflict of Interest ***(CoC 1)*** *** LEGAL SIZED PAPER ***
_____ **20.** Limited English Proficiency Notice – Section 8 ***(form LEP-02), 2 pages***
_____ **21.** CoC Tenant-Based Family Obligations ***(HAPP-149), 2 pages,*** *signed by **all** adults* *** LEGAL SIZED PAPER ***
_____ **22.** Certified Statement – Yes/No Questionnaire (***form ANC-19***), *for **all** adults 18 years of age and older*
_____ **23.** Authorization for Release of Confidential DPSS Information ***(form RE-DPSS)***
_____ **24.** Verification of DPSS Assistance ***(form RE-29)*** *** LEGAL SIZED PAPER ***
_____ **25.** CalWORKs Homelessness Certification ***(form ANC-CW-1),*** *signed by **all** adults*
_____ **26.** Reasonable Accommodation Questionnaire ***(form S504-02)*** *** LEGAL SIZED PAPER ***
_____ **27.** DedicatedPLUS Timeline, 2 pgs
_____ Third Party Verification of Homeless Status Form, 2 pgs
_____ Observation of Homeless Status Form, 2 pgs
_____ Self-Certification of Homeless Status Form, 2 pgs
_____ DedicatedPLUS Verification Pack, 1 pg
_____ HMIS Printout – Client Timeline Enrollments
_____ **28.** Verification of Disability Form, 2 pgs
_____ **29.** Statement of Family Responsibility (Supportive Services) ***(form Special Programs – supp)***
_____ **30.** Optional Designation of Authorized Representative/Signatory
_____ **31.** Certified Statement ***(form RE-46)***
_____ **32.** Verification of Income (refer to item #12 on this checklist to provide different types of verification that apply)
_____ **33.** Identification Documents
____ Current California Photo ID or Current California Driver's License, *for **all** adults in the household*
____ Permanent Residence Card – both sides, (if applicable)
____ Signed Social Security Cards, *for **all** household members*
____ Birth Certificates, *for **all** minors in the household*

Client Name: _____ **SSN:** _____

Submitted by: _____ **Date:** _____

Agency: DMH / _____ **Agency Phone #:** _____

Service Area: _____ **Supervisorial District:** _____

County of Los Angeles - Department of Mental Health
Housing and Job Development Division

HOUSING INTAKE AND NEEDS ASSESSMENT

_____
Date of Assessment

Housing History:

What is client's current living situation?

☐ Motel ☐ Board and Care ☐ Streets, car, parks ☐ Transitional residential program
☐ Sober living home ☐ Friends/family ☐ Homeless shelter
☐ Apartment/SRO ☐ Other _____

Specify name or closest street: _____

Length of time in current situation? ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 12 months or longer

How many people does client live with? _____

Who does client live with? _____

Does client share a room? ☐ Yes ☐ No If yes, with whom? _____

Does client pay rent? ☐ Yes ☐ No If yes, how much? _____

Does client have a key? ☐ Yes ☐ No Does client's unit have running water/electricity? ☐ Yes ☐ No

Does client have access to bathroom and cooking facilities? ☐ Yes ☐ No

What kind of agreement does client have to live there? (lease/informal agreement)

_____

Financial Situation:

What is client's total monthly income? _____

Source of Income: ☐ SSI ☐ GR ☐ VA ☐ SSDI ☐ SDI ☐ CALWORKs/TANF
☐ Food Stamps ☐ Child Support ☐ Employment ☐ Other (such as family support)
☐ Unemployment Insurance ☐ None

Is income expected in the future? ☐ Yes ☐ No If yes, how much? _____

Does client have a payee? ☐ Yes ☐ No Does client have a savings/checking account? ☐ Yes ☐ No

Has client ever served in the United States Military? ☐ Yes ☐ No

Is client eligible for Military/Veterans benefits? ☐ Yes ☐ No

Transportation:

Does client own a vehicle? ☐ Yes ☐ No Does client use public transportation? ☐ Yes ☐ No

Criminal Convictions:

	Client:	Other Household Members:	Date of Conviction:
Drug-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Production/manufacture of Methamphetamine?	☐ Yes ☐ No	☐ Yes ☐ No	
Violence-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Registered as a sex offender?	☐ Yes ☐ No	☐ Yes ☐ No	
Arson?	☐ Yes ☐ No	☐ Yes ☐ No	

_____ _____
Print Client Name IS #

DMH /
Agency/Program

Independent Living Supports/Assistance Needed:

Temporary	Ongoing	
☐	☐	Bathing
☐	☐	Care of personal hygiene
☐	☐	Cooking/preparing foods
☐	☐	Laundry
☐	☐	Housekeeping/cleaning
☐	☐	Making/keeping the home safe
☐	☐	Accessing healthcare and medical issues
☐	☐	Grocery shopping
☐	☐	Public/private transportation
☐	☐	Budgeting/banking/money management
☐	☐	Social skills/interpersonal relationships
☐	☐	Exhibiting appropriate behaviors as outlined in lease agreement
☐	☐	Accessing services in crowded places
☐	☐	Paying rent
☐	☐	Maintaining important personal documents and files
☐	☐	Walking a reasonable distance
☐	☐	Ability to wait in line for services
☐	☐	Using public facilities (i.e., post office)

Housing Plan:

How much can client afford to pay in rent? ☐ $0-$300 ☐ $301-$600 ☐ $601-$1,000 ☐ $1,001+

Who will live with the client? _____

_____ Number of minor children _____ Number of adults _____ Number/kind of pets

Does client have a poor credit history? ☐ Yes ☐ No

Does client have financial resources to pay for move-in expenses? ☐ Yes ☐ No

Does client need household furnishings/appliances? ☐ Yes ☐ No

Where does client want to live? Service Area: _____ City: _____

Does anyone in the client's family have physical limitations that would require accommodations? ☐ Yes ☐ No

If yes, what accommodations? _____

Mark all of the following housing situations that client would consider to be acceptable:

Co-Ed environment?	☐ Yes ☐ No	Sharing a unit/room with another family or individual?	☐ Yes ☐ No
Emergency shelter?	☐ Yes ☐ No	Shared or collaborative housing?	☐ Yes ☐ No
DMH Temporary Shelter Program?	☐ Yes ☐ No	Residential drug treatment program?	☐ Yes ☐ No
Sober living home?	☐ Yes ☐ No	Apartment unit/SRO?	☐ Yes ☐ No

In what ways does client need help in locating housing? ☐ Housing referrals ☐ Housing search ☐ Transportation ☐ Completing application ☐ Other _____

Has client ever been evicted from non-subsidized housing? ☐ Yes ☐ No

If yes, how many evictions has client had in the last 10 years? _____

Is client interested in applying for any of the following permanent housing options?

☐ Homeless Section 8 ☐ Shelter Plus Care (SPC) ☐ Section 8 ☐ Project Based Section 8/SPC housing

If yes, complete the questions on the following page:

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Shelter Plus Care (SPC) or Homeless Section 8 Eligibility Assessment *(Only Complete If Applicable)*:

Does the client meet HUD homeless criteria (reside in a place not fit for human habitation such as the streets, a park, a car, abandoned buildings, etc., an emergency shelter, transitional housing for clients who originally came from the streets or an emergency shelter, any of these but is spending a short time in a hospital or other institution, residing in a hospital or institution longer than 30 days if there is no discharge plan and the person would be homeless upon discharge, living in a private dwelling and be within one week of a sheriff's eviction with no resources or subsequent residence identified)?

☐ Yes ☐ No

Has the client been HUD homeless for a continuous year or longer? ☐ Yes ☐ No

Has client ever been evicted from a Governmental subsidized housing program (Sec. 8, SPC etc.)? ☐ Yes ☐ No

If client is currently homeless, how many episodes of HUD homelessness has s/he had in the last three years?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Is client a US citizen or legal resident? ☐ Yes ☐ No

Does client reside in:

A place not meant for human habitation such as the streets, a car, abandoned buildings, parks, bus stations, doorways, etc.? ☐ Yes ☐ No

A homeless shelter? ☐ Yes ☐ No

Transitional or supportive housing for homeless persons who originally came from the streets or a homeless shelter? ☐ Yes ☐ No

Any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution and would otherwise sleep in the types of places described above? ☐ Yes ☐ No

A hospital or institution longer than 30 days if there are no resources available or discharge plan in place and the individual will be homeless when discharged? ☐ Yes ☐ No

A private dwelling and be within one week of a Sheriff's eviction (has eviction papers) with no subsequent residence identified, and lacks the resources and support networks to obtain housing? ☐ Yes ☐ No

Is client fleeing from domestic violence? ☐ Yes ☐ No

Shelter Plus Care is designed for clients who need intensive supportive services such as those in Full Service Partnerships (FSP).

Is the client expected to receive approximately $12,000/yr. worth of ongoing supportive services for at least 5 years? ☐ Yes ☐ No

If the client wants to apply for Homeless Section 8:

Will s/he be receiving supportive services for at least 1 year after lease up? ☐ Yes ☐ No

Is client willing to have at least 4 housing visits in the 1st year of occupancy? ☐ Yes ☐ No

What is the client's housing goal? _____

What have been/are barriers to permanent housing? _____

What are the steps/plan to help client achieve housing goal (include how barriers will be addressed)?

_____

_____

_____

_____

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Provider Signature: _____ Client Signature: _____

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GREATER LOS ANGELES & ORANGE COUNTY
HOMELESS MANAGEMENT INFORMATION SYSTEM (LA/OC HMIS)

CONSENT TO SHARE PROTECTED PERSONAL INFORMATION

The LA/OC HMIS is a local electronic database that securely record information (data) about clients accessing housing and homeless services within the Greater Los Angeles and Orange Counties. This organization participates in the HMIS database and shares information with other organizations that use this database. This information is utilized to provide supportive services to you and your household members.

What information is shared in the HMIS database?

We share both Protected Personal Information (PPI) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information
- Your social security number
- Your birthdate
- Your basic demographic information such as gender and race/ethnicity
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Your self-reported medical history, including any mental health and substance abuse issues
- Your case notes and services
- Your case manager's contact information
- Your income sources and amounts; and non-cash benefits
- Your veteran status
- Your disability status
- Your household composition
- Your emergency contact information
- Any history of domestic violence
- Your photo (optional)

How do you benefit from providing your information?

The information you provide for the HMIS database helps us coordinate the most effective services for you and your household members. By sharing your information, you may be able to avoid being screened more than once, get faster services, and minimize how many times you tell your 'story.' Collecting this information also gives us a better understanding of homelessness and the effectiveness of services in your local area.

Who can have access to your information?

Organizations that participate in the HMIS database can have access to your data. These organizations may include homeless service providers, housing groups, healthcare providers, and other appropriate service providers.

How is your personal information protected?

Your information is protected by the federal HMIS Privacy Standards and is secured by passwords and encryption technology. In addition, each participating organization has signed an agreement to maintain the security and confidentiality of the information. In some instances, when the participating organization is a health care organization, your information may be protected by the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, you understand and agree that:

- You have the right to receive services, even if you do not sign this consent form.
- You have the right to receive a copy of this consent form.
- Your consent permits any participating organization to add to or update your information in HMIS, without asking you to sign another consent form.
- This consent is valid for seven (7) years from the date the PPI was created or last changed.
- You may revoke your consent at any time, but your revocation must be provided either in writing or by completing the *Revocation of Consent* form. Upon receipt of your revocation, we will remove your PPI from the shared HMIS database and prevent further PPI from being added. The PPI that you previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided you with direct services.
- The Privacy Notice for the LA/OC HMIS contains more detailed information about how your information may be used and disclosed. A copy of this notice is available upon request.
- No later than five (5) business days of your written request, we will provide you with:
    - A correction of inaccurate or incomplete PPI
    - A copy of your consent form
    - A copy of your HMIS records; and
    - A current list of participating organizations that have access to your HMIS data.
- Aggregate or statistical data that is released from the HMIS database will not disclose any of your PPI.
- You have the right to file a grievance against any organization whether or not you sign this consent.
- You are not waiving any rights protected under Federal and/or California law.

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your minor children (if any), entered into the HMIS database. You also consent to share your information with other participating organizations as described in this consent form.

☐ **I consent to sharing my photograph. (Check here)**

Client Name: _____ DOB: _____ Last 4 digits of SS_____

Signature _____Date _____

☐ **Head of Household (Check here)**

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

_____ _____

Print Name of Organization Staff **Print Name of Organization**

_____ _____

Signature of Organization Staff **Date**

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Client Profile *(required questions are shaded)*

HMIS Consent signed (Release of Information Permission): ☐ No ☐ Yes Date consented (Start Date):_____/_____/_____

Social Security Number	_____-_____-_____
Quality of SSN	☐ Full SSN reported ☐ Client doesn't know ☐ Data not collected ☐ Approximate or partial SSN reported ☐ Client refused
Last Name	
First Name	
Quality of Name	☐ Full Name Reported ☐ Client doesn't know ☐ Data not collected ☐ Partial, street name, or code name reported ☐ Client refused
Quality of DOB	☐ Full DOB reported ☐ Client doesn't know ☐ Data not collected ☐ Approximate or partial DOB reported ☐ Client refused
Date of Birth	_____/_____/_____
Middle Name	Suffix:
Maiden Name	
Alias	
Gender	☐ Female ☐ Client doesn't know ☐ Male ☐ Client refused ☐ Trans Female (MTF or Male to Female) ☐ Data not collected ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (i.e. not exclusively male or female)
Ethnicity	☐ Non-Hispanic ☐ Client doesn't know ☐ Data not collected ☐ Hispanic ☐ Client refused
Race	☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African-American ☐ Client doesn't know ☐ Asian ☐ Client refused ☐ American Indian or Alaskan Native ☐ Data not collected
Primary Language	
TB Clearance Date	_____/_____/_____ Clinic:
Have you ever served in the U.S. Military? (Veteran Status)	☐ No ☐ Client doesn't know ☐ Data not collected ☐ Yes ☐ Client refused

If the client identifies as Yes to veteran status, then the following questions are required:

Dates of military service (Year Only)	_____ to _____			
Branch of Military	☐ Army ☐ Navy ☐ Coast Guard ☐ Client refused ☐ Air Force ☐ Marines ☐ Client doesn't know ☐ Data not collected			
Discharge Status	☐ Honorable ☐ Bad Conduct ☐ Client doesn't know ☐ General under honorable conditions ☐ Dishonorable ☐ Client refused ☐ Under other than honorable conditions (OTH) ☐ Uncharacterized ☐ Data not collected			
Theater of Operations	World War II	Korean War	Vietnam War	Persian Gulf War
	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused
	Afghanistan (Enduring Freedom)	Iraq (Iraqi Freedom)	Iraq (New Dawn)	Other Operations
	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused	☐ No ☐ Don't know ☐ Yes ☐ Refused

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Documentation *(Files)*

Check all that are in the client's possession:		
☐ Birth Certificate	☐ Proof of Residency	☐ VA Release
☐ Certificate of Disability	☐ Reference Letter	☐ LACDMH 677 Authorization Consent
☐ DD214 (Veterans Only)	☐ Social Security Card	☐ DHS Pre-release
☐ Driver's License / CA ID	☐ TB Certification	☐ Other:
☐ Homeless Verification	☐ Verification of Income	

Client Contact Information *(Location)*

Address Type:		
☐ Home ☐ Work ☐ School ☐ Mailing ☐ Emergency ☐ Father ☐ Mother ☐ Spouse ☐ Temporary ☐ Other ☐ Legal Guardian ☐ Message ☐ Management Company ☐ Forwarding Address	Name	
	Address 1	
	Address 2	
	City	
	State	
	Zip Code	
	Email	
	Phone 1	
	Phone 2	

Outreach Contact Information *(Location)*

Address Type: ☐ Outreach Date Contacted: _____ / _____ / _____	Client Name	
	Address 1	
	Address 2	
	City	
	State	
	Zip Code	
	Email	
	Phone 1	
	Phone 2	

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Program Entry *– All clients, all fields required unless otherwise noted*

Program Name: _____ **Case Manager:** _____

1. Program Start Date	_____/_____/_____	
2. Relationship to Head of Household	□ Self (Head of Household) □ Head of household's child □ Head of Household's spouse or partner	□ Head of household's other relation member □ Other: non-relation member
4. Client Location (CoC)	□ CA-600 – Los Angeles □ CA-602 – Orange County □ CA-606 – Long Beach □ CA-607 – Pasadena □ CA-611 – Ventura County □ CA-612 – Glendale	□ CA-614 – San Luis Obispo County

CES Placement *– Permanent Housing and Transitional Housing only*

5. Was the client placed into this housing program through CES?	□ No □ CES for Single Adults □ CES for Families □ CES for Youth

Housing Move-In *– Rapid Re-housing, Permanent Housing, and Street Outreach projects only, only required for Head of Household*

6. Has the client moved-in to permanent housing?	□ No □ Yes: Housing Move-In Date: _____/_____/_____

Outreach *– Outreach projects only, all fields required unless otherwise noted*

7. Has the client been engaged? Engagement means an interactive client relationship results in a deliberate client assessment.	□ No □ Yes: Engagement Date: _____/_____/_____

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Homelessness *– Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH:

9. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	**10. How long was the client staying in that place?** *(Length of stay in prior living situation)*	**10a/b Did the client stay less than…**
Literally Homeless Situations ☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing	***For literally homeless situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	**Not Applicable** *Go to question 11*
Institutional Situations ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	***For institutional situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***10a: 90 days:*** ☐ Yes *Go to question 10c* ☐ No *Go to question 20*
Transitional & Permanent Housing Situations ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other housing subsidy (including RRH) ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth)	***For transitional & permanent housing situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***10b: 7 nights:*** ☐ Yes *Go to question 10c* ☐ No *Go to question 20*
Other ☐ Client doesn't know ☐ Client refused ☐ Data not collected		

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

FOR EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH PROJECTS:

9. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other housing subsidy (including RRH) ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ☐ Client doesn't know ☐ Client refused ☐ Data not collected
10. How long was the client staying in that place? *(Length of stay in prior living situation)*	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected

After asnwering question 10, go to question 11

If the client is coming from an institution after having stayed less than 90 days or if the client is coming from a transitional, permanent, or other situation after having stayed less than 7 nights, then the following question is required:

10c. On the night before your current housing situation, did you stay on the streets, in an emergency shelter, or at a safe haven?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

If the project being entered is an emergency shelter, safe haven, or street outreach, or if the client answered questions #4 and #5, then the following questions are required:

11. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date homelessness started)*	_____/_____/_____	
12. In the past three years, how many times have you returned to the streets, an emergency shelter, or a safe haven after being housed? *(Number of times on the streets, in ES, or Safe Haven in the past three years including today)*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times	☐ Client doesn't know ☐ Client refused ☐ Data not collected

13. In those three years, what is the total number of months spent homeless on the streets, in an emergency shelter, or in a safe haven? *(Total number of months homeless on the street, in ES, or SH in the past three years)*	☐ One Month (this time is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months	☐ Client doesn't know ☐ Client refused ☐ Data not collected

Continue for all clients:

Disabling Conditions and Barriers *- All fields required unless otherwise noted*

21. Do you have a physical disability?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client refused ☐ Data not collected
If question #21 was answered as "Yes" (**), then the following questions are **required**:		
21a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
22. Have you ever been told you have a learning disability or developmental disability?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client refused ☐ Data not collected
If question #22 was answered as "Yes" (**), then the following questions are **required**:		
22a. Do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
23. Do you have a chronic health condition? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition; stroke****; or* ***emphysema****.*	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client refused ☐ Data not collected
If question #23 was answered as "Yes" (**), then the following questions are **required**:		
23a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
24. Have you been diagnosed with AIDS or have you tested positive for HIV?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client refused ☐ Data not collected
If question #24 was answered as "Yes" (**), then the following questions are **required**:		
24a. Do you expect this to substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
25. Do you feel you currently have a mental health problem?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client refused ☐ Data not collected
If question #25 was answered as "Yes" (**), then the following questions are **required**:		
25a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

26. Do you *currently* have a drug or alcohol problem?	☐ No ☐ Client doesn't know ☐ Alcohol* ☐ Client refused ☐ Drug* ☐ Data not collected ☐ Both*
If question #26 was answered as "Alcohol", "Drug", or "Both" (**), then the following questions are **required**:	
26a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Client doesn't know ☐ Yes ☐ Client refused ☐ Data not collected
27. Have you been a victim of domestic violence or a victim of intimate partner violence?	☐ No ☐ Client doesn't know ☐ Yes** ☐ Client refused ☐ Data not collected
If question #27 was answered as "Yes" (**), then the following question is **required**:	
27a. If you experienced domestic or intimate partner violence, how long ago did you have this experience?	☐ Within the past three months ☐ Three to six months ago ☐ From six to twelve months ago ☐ More than a year ago ☐ Client doesn't know ☐ Client refused ☐ Data not collected
27b. Are you currently fleeing?	☐ No ☐ Client doesn't know ☐ Yes ☐ Client refused ☐ Data not collected

SURVEYOR ONLY – DO NOT ASK: **28. Is the client chronically homeless?** *To be chronically homeless, the client must be an unaccompanied homeless individual (or adult in a family) with a disabling condition who has been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness totaling one year in duration in the past three years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time.*	☐ Not chronically homeless ☐ Chronically homeless because of continuous homelessness 1 year or more ☐ Chronically homeless because of 4 or more episodes of homelessness in 3 years

Tuberculosis *– Emergency Shelters only, all fields required unless otherwise noted*

29. Do you have a cough that has lasted longer than 3 weeks?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused
30. Have you recently lost weight without explanation during the past month?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused
31. Have you had frequent night sweats during the past month, soaking your sheets or clothing?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused
32. Have you coughed up blood in the past month?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused
33. Have you been feeling much more tired than usual over the past month?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused
34. Have you had fevers almost daily for more than one week?	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Employment *- For adults18 and older and/or Head of Household, all fields required unless otherwise noted*

35. Are you currently employed?	☐ No*	☐ Client doesn't know
	☐ Yes**	☐ Client refused
If question #35 was answered as "No" (*), then the following question is **required**:		
35a. Are you…. *(read options to the right)*	☐ Looking for work	☐ Not looking for work
	☐ Unable to work	
If question #35 was answered as "Yes" (**), then the following question is **required**:		
35b. What type of employment do you have?	☐ Full-time	☐ Seasonal / sporadic (including day labor)
	☐ Part-time	

Cash Income for Individual *- For adults18 and older and/or Head of Household, all fields required unless otherwise noted*

36. Do you receive any cash income?	☐ No	☐ Client doesn't know	☐ Data not collected
	☐ Yes	☐ Client refused	

If question #36 was answered as "Yes", then the following question is **required**:

Income Source and Monthly Income: *What sources of income do you have, and how much do you get on a monthly basis?*

☐ Earned Income (employment wages / cash)	$	☐ CalWorks	$
☐ Unemployment Insurance	$	☐ General Assistance (GA) / General Relief (GR)	$
☐ Supplemental Security Income (SSI)	$	☐ Retirement Income from Social Security	$
☐ Social Security Disability Insurance (SSDI)	$	☐ Pension or retirement income from a former job	$
☐ VA Service-Connected Disability Compensation	$	☐ Child Support	$
☐ VA Non-Service-Connected Disability Pension	$	☐ Alimony and other spousal support	$
☐ Private Disability Insurance	$	☐ Other Source (Specify:_____)	$
☐ Worker's Compensation	$		

36a. Income Documentation *Do you have documents that verify income?*	☐ GR Form	☐ CalWORKs Form	☐ Pension Letter/Stub
	☐ Pay Stub	☐ Unemployment Insurance Forms	☐ Unemployment Forms
	☐ Utility Allowance	☐ W-2 Forms	☐ Self Declaration
	☐ Child Support Forms	☐ SSDI Form	☐ Employer Printout/Letter
	☐ Social Security Forms	☐ Workmans Comp	☐ VA Documentation
	☐ SSI Forms	☐ Self Employment Docs	☐ Other (Specify:)

Non-Cash Benefits *- For adults18 and older and/or Head of Household, all fields required unless otherwise noted*

37. Do you receive any non-cash benefits?	☐ No	☐ Client doesn't know	☐ Data not collected
	☐ Yes	☐ Client refused	

If question #37 was answered as "Yes", then the following question is **required**:

Non-Cash Benefits *What non-cash benefits do you receive? (Check all that apply)*	☐ Food Stamps/CalFresh (Supplemental Nutrition Assistance Program, SNAP)
	☐ WIC (Special Supplemental Nutrition Program for Women, Infants, and Children)
	☐ CalWorks child care services
	☐ CalWorks transportation services
	☐ Other CalWorks-funded services
	☐ Other source (Specify:_____)

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Health Insurance *- All clients, all fields required unless otherwise noted*

38. Are you covered by any type of health insurance?	☐ No ☐ Yes	☐ Client doesn't know ☐ Data not collected ☐ Client refused

If question #37 was answered as "Yes", then the following questions are **required**:

Health Insurance *(Check all that apply):*	☐ Medi-Cal (MEDICAID) ☐ MEDICARE ☐ State Children's Health Insurance Program (SCHIP) ☐ VA medical services ☐ Employer-provided health insurance ☐ COBRA	☐ Private pay health insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other health insurance (Specify:_____)
38a. Health Insurance Provider	☐ Health Net ☐ Molina ☐ My Health LA (DHS) ☐ Anthem Blue Cross ☐ Kaiser Permanente	☐ VA ☐ L.A. Care ☐ Care 1st Health Plan ☐ Other ☐ Unknown

Youth/TAY *– Clients aged 16-24 only, all fields required unless otherwise noted*

39. Did you run away from home or a foster care home?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused
40. Are you a current or former foster care youth?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused
41. Have you ever been in the juvenile justice system?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused
42. Have you ever been on adult probation?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused
43. Which of the following best represents how you think about yourself?	☐ Heterosexual ☐ Lesbian ☐ Questioning/Unsure ☐ Gay ☐ Bisexual	☐ Client doesn't know ☐ Client refused

Health and Education *– All clients, all fields required unless otherwise noted*

44. Are you pregnant?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused

If question #44 was answered as "Yes" (*), then the following question is **required**:

44a. What is your due date?	___/___/_____

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	**Last Name**
Street Address	**City, State, Zip**
IBHIS Number	**Birth Date**
	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Los Angeles Homeless Management Information System (HMIS).

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in the Section 8 Special Programs application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for the Section 8 Special Program, assistance with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as entering information into the HMIS managed by the Los Angeles Homeless Services Authority. This information will also be used to coordinate services and track client information.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the Section 8 Special Program participant is no longer receiving housing subsidy services through Department of Mental Health's grant with City and/or County Housing Authorities.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:_____

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Housing and Job Development Division Federal Housing Subsidies Unit, 510 S. Vermont Ave., 17th Floor, Los Angeles, CA 90020. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:_____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	Last Name
Street Address	**City, State, Zip**
IBHIS Number	**Birth Date** / **Phone Number** ( )

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Housing Authority of the City of Los Angeles (HACLA), Special Program Operations and Administration.

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in HACLA's housing subsidy application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for housing subsidies assistance, with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as providing quarterly and annual reports.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

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LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the housing subsidies program participant is no longer receiving services through Department of Mental Health's grant with HACLA.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Housing and Job Development Division Federal Housing Subsidies Unit, 510 S. Vermont Ave., 17th Floor, Los Angeles, CA 90020. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING AND JOB DEVELOPMENT DIVISION

CONTINUUM OF CARE PROGRAM
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the DMH or ICMS Program Agency Manager:

Name of Participant: _____

Name of DMH or ICMS Agency: _____

The program manager will ensure that the Continuum of Care (CoC) participant will have an assigned case manager who be responsible for the following for the duration of client participation in the program:

- Use a Housing First approach to assist clients with immediate access to housing and the supports needed to retain housing.

- Assist the client with completing the required documents by the Housing Authority of the City of Los Angeles (HACLA) or Los Angeles County Development Authority (LACDA) and accompany the participant to the scheduled meetings with Housing Authorities.

- Assist the client in a housing search.

- Send signed lease agreements to the Federal Housing Subsidies Unit (FHSU) when received.

- Ensure that the agency remains updated regarding participant's current contact information.

- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.

- Conduct needs assessments to determine appropriate linkage to community-based services such as health care, childcare, alcohol and other substance abuse, education and/or job training, and other services essential for achieving and maintaining independent living.

- Conduct ongoing assessments/evaluations to monitor progress and provide appropriate interventions as needed.

- Provide a Housing Annual Assessment form that incorporates the current housing goal to ensure compliance with housing contracts between DMH and the Housing Authorities. This should be submitted to FHSU each year on the anniversary of the lease up date.

- Update the participant's Client Care Coordination Plan (CCCP) annually and include any appropriate housing-related goals.

- Document housing supportive services in clinical file, including but not limited to: CES survey completion and entry into HMIS, assistance with applications, accompanying client to Housing Authority, housing search and housing stabilization.

- Submit signed MH 677, Authorizations for Request and Use/Disclosure of Protected Health Information (PHI) to allow DMH to disclose PHI to the Housing Authority (MH 677 HACLA or MH 677 LACDA) and to the Los Angeles Homeless Services Authority/Homeless Management Information System (MH 677 HMIS), and a signed MH 601E, Acknowledgement of Receipt of the LACDMH Notice of Privacy Practices.

- Comply with all requirements of McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.) including that they ensure and monitor that households with school-aged minors are enrolled in school and receive entitled benefits.

- Complete all required reports and any other requested documentation including the Quarterly Report Survey (HACLA) and Client Progress Report - Quarterly Review (LACDA). These records will be subject to audit by HUD and the local Housing Authority administering the grant.

- Participate in regularly scheduled Housing Liaison meetings to obtain updates on program requirements.

- Assist the client with completing his/her paperwork for the Annual Recertification Packet (HACLA) or Annual Re-exam Packet (LACDA).

- If the participant is transferred to another directly-operated or contracted DMH agency/program, ensure that the new program is aware that the client is a CoC participant and that they understand the requirements of the program by gaining the signature of the new Program Manager on the Service Provider Responsibility form and submitting it to FHSU.

- Notify FHSU if the participant abandons his/her unit, is deceased, or terminated from CoC.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

Date: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CONTINUUM OF CARE
PARTICIPANT AGREEMENT

As a participant in the Continuum of Care (CoC) Program with the Housing Authority of the City of Los Angeles (HACLA) or Los Angeles County Development Authority (LACDA), **I agree to abide by the following program expectations**:

1. Maintain contact and meet, as necessary, with my case manager at a minimum of once monthly for as long as I am a participant in the CoC Program.
2. Participate in the development of the Client Coordination Care Plan (CCCP) with my service provider team to pursue my recovery goals.
3. Participate in supportive services to pursue my recovery goals including vocational and educational assistance, life skills classes, budget and money management classes, nutritional planning, and any other supportive services as deemed necessary.
4. Receive quarterly home visits from my service provider team.
5. Abide by the terms of my lease agreement.
6. Provide a signed lease agreement to my service provider team in a timely manner.
7. Provide my service provider team with updated contact information (phone number, address, emergency contact. etc).
8. If applicable, provide my service provider team with information about any school-aged minors in my household and whether they are enrolled in school and receiving entitled benefits so that DMH can be in compliance w/ McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.).
9. _____
   _____
10. _____
    _____

Print Client's Name: _____

Client's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

Translated by: _____ Date: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING AND JOB DEVELOPMENT DIVISION

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

Our agency / program certifies that we are ensuring this program participant is assisted in applying for ACA Health Benefits, if appropriate (or officially opting out) and maintaining documentation indicating if the assistance was provided and completed on-site or if a referral was made to an off-site agency.

☐ Check here if participant already has health insurance such as Medi-Cal or Medicare

Name of Participant: _____

Name of Agency: _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

NOTICE TO HOUSEHOLDS WITH SCHOOL-AGE YOUTH
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

- Go to school, even if they do not have a permanent address
- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
- Have access to the same services and programs that are available to all other students
- Receive transportation to school from their current residence
- Automatically be enrolled in free lunch or free meal programs

The following resources can assist you to access educational benefits for your family:

Los Angeles County Office of Education Website:

http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

Los Angeles County Office of Education Contact

Melissa Schoonmaker
School Attendance Review Board/McKinney-Vento Homeless Education Program Manager
Email: homeless_program@lacoe.edu
Phone: (562) 922-6233 Fax: (562) 922-6781
Student Support Services - Education Center West (formerly Clark)
12830 Columbia Way, ECW-3236, Downey, CA 90242

Los Angeles Unified School District (LAUSD):

LAUSD Web site

http://homelesseducation.lausd.net/

LAUSD Contact

Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

Los Angeles County

DEPARTMENT OF MENTAL HEALTH

ACKNOWLEDGEMENT OF RECEIPT

MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

- Go to school, even if they do not have a permanent address
- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
- Have access to the same services and programs that are available to all other students
- Receive transportation to school from their current residence
- Automatically be enrolled in free lunch or free meal programs

The following resources can assist you to access educational benefits for your family:

Los Angeles County Office of Education Website:

http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

Los Angeles County Office of Education Contact

Melissa Schoonmaker
School Attendance Review Board/McKinney-Vento Homeless Education Program Manager
Email: homeless_program@lacoe.edu
Phone: (562) 922-6233 Fax: (562) 922-6781
Student Support Services - Education Center West (formerly Clark)
12830 Columbia Way, ECW-3236, Downey, CA 90242

Los Angeles Unified School District (LAUSD):

LAUSD Web site

http://homelesseducation.lausd.net/

LAUSD Contact

Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

I acknowledge receiving this notice and the attached bulletin: _____
Print Name

_____ _____
Signature Date

You can ENROLL in school!

Even if you have:

- **Uncertain housing**
- **A temporary address**
- **No permanent physical address**

You are guaranteed enrollment in school by the federal McKinney-Vento Act and California state law if you live:

- In a shelter (family, domestic violence, or youth shelter or transitional living program)
- In a motel, hotel, or weekly rate housing
- In a house or apartment with more than one family because of economic hardship or loss
- In an abandoned building, in a car, at a campground, or on the street
- In temporary foster care or with an adult who is not your parent or guardian
- In substandard housing (without electricity, water, or heat)
- With friends or family because you are a runaway or an unaccompanied youth

To enroll in or attend school if you live under any of these conditions, you do NOT need to provide:

- Proof of residency
- Immunization records or tuberculosis skin-test results
- School records
- Legal guardianship papers

You may:

- Participate fully in all school activities and programs for which you are eligible.
- Continue to attend the school in which you were last enrolled even if you have moved away from that school's attendance zone or district.
- Receive transportation from your current residence back to your school of origin.
- Qualify automatically for child nutrition programs (free and reduced-price lunches and other district food programs).
- Contact the district liaison to resolve any disputes that arise during the enrollment process.

Parents' responsibilities are to:

- Make sure your child attends school regularly and completes homework and projects on time.
- Attend parent/teacher conferences, Back-to-School Nights, and other school-related activities.
- Stay informed of school rules, regulations, and activities.
- Participate in school advisory/decision-making activities.

For questions about enrolling in school or for assistance with school enrollment, contact:

Your local school district liaison:

Nancy Gutierrez
Pupil Service and Attendance Coordinator
LAUSD Homeless Education Program,
Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012
Phone: 1-213-202-7581

Your county liaison for the homeless:

Melissa Schoonmaker
Homeless Education Program Manager
School Attendance Review Board /
McKinney-Vento
12830 Columbia Way, ECW-3236
Downey, CA 90242
Phone: 1-562-922-6233

Your state coordinator for the homeless:

Leanne Wheeler
State Coordinator
California Department of Education
1430 N Street, Suite 6208
Sacramento, California 95814
Phone: 1-866-856-8214

California Department of Education

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
FEDERAL HOUSING SUBSIDIES UNIT

Sample Format for Case Manager / Housing Liaison Referral Letter

Must be on Agency letterhead.

First Paragraph

- Just one or two sentences describing your agency's program(s) (Attaching an agency brochure helps.)
- Applicant's entry date into your agency's program
- Applicant's exit date from your agency's program. (If applicable, explain why the Applicant is leaving your agency's program, and identify the linkage schedule and the next provider to whom Applicant will be linked--agency name, case manager name and phone number.)
- Say where the applicant is living at the present time.
    - If he or she is in a shelter ask the shelter to write a letter on their letterhead (and add their pamphlet, if available).
    - If the applicant is living on the "streets," include information specifying where he or she can be found (e.g., "Ms. Jones resides in the alley directly behind the Baja Fresh Restaurant located at 6043 Hollywood Boulevard, Hollywood, CA 90028. I have met with her for case management at this location on the following dates: 01/23/04, 02/06/04, 03/10/04, and 04/13/04. She was noted by police citation for sleeping in this alley on the flowing dates: 05/23/04, and 05/30/04."

Troubleshooting

- If exit date at shelter has passed, then explain why the Applicant is still in the program.
- *Example*: "Even though Mr. Smith's residential time at XYZ Shelter has expired, we received permission to allow him to stay here until he is approved for a Continuum of Care Certificate. "
- Be mindful if you allow an Applicant to stay at your facility past their expiration date (i.e., identify why and for how long).

Second Paragraph

- Narrative outline of the Applicant's homeless history, with **NO** time gaps.
- Identify time periods Applicant can't recall, if any.
- This detailed history should begin from when Applicant began seeing the case manager. If that time is less than two years, then the case manager should include the Applicant's recollection of their homelessness prior to engagement.
- Include (1) the specific date Applicant first became homeless and (2) the event that caused Applicant's to become homeless. If the event is documented (e.g., eviction papers, motel receipts, etc.) reference them here and include them in the application.

- Identify and explain **all** Applicant telephone numbers and addresses disclosed **anywhere** in the application package, including the address on the Applicant's CDL or other photo ID.
- Explain why Applicant cannot live at / return to these addresses

Third Paragraph

- Explain why you think this Applicant meets target population for Continuum of Care (Remember: the Applicant has to require a high level of service enough to meet the service match).
- Mental illness should only be mentioned; do not indicate client's diagnosis (e.g., "Mr. Burnett has a mental illness, attends all appointments regularly at the clinic, and is medication compliant.")
- Explain your Applicant's experience with your program
- Always include strengths and positive points concerning the applicant
- Mention Independent Living Skills, especially money management. (Place the person you have chosen for a Continuum of Care Certificate into a Community Living Program or Independent Living Skills class.)

Fourth Paragraph

- If children are involved, please state: (1) where they are, (2) who is supporting them, and (3) if the child is in placement, attach court paperwork indicating who has custody and a letter from the Children's Social Worker indicating that the child will be allowed to reside with the applicant in the apartment.
- Criminal Background Checks: Criminal background checks are required for all adult family members (18 years and over) that will be residing with the applicant. Provide information concerning the following:
    - If the adult family member has been convicted of any drug or alcohol related offense, explain and document what treatment (including residential and out patient substance abuse treatment, 12-step meetings, etc.) he or she has been involved in and completed.
    - If the adult family member has been convicted of a violent offence, explain and document what treatment (including anger management classes, and individual therapy, etc.) he or she has been involved in and completed.

Fifth Paragraph

- Closing remarks and contact information for referring clinician or case manager.

Salutation,

Signature
Title

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

SAMPLE REFERRAL LETTER

November 1, 2020

Eligibility Interviewer
Housing Authority of the City of Los Angeles
Special Programs Operation
2600 Wilshire Blvd., 2nd Fl
Los Angeles, CA 90057

RE: Jane Doe, SS# 123-45-6789

Housing Authority of the City of Los Angeles:

I am writing this letter in support of Jane Doe's Continuum of Care application. Jane has been a client of the ACTION program since October 18, 2015. ACTION is an assertive community treatment program that assists dually diagnosed consumers with psychotherapy, case management, and psychiatry. Jane has a mental illness and has maintained all scheduled appointments with me for counseling and sees her psychiatrist regularly despite her lack of a fixed nightly residence.

Jane became homeless on January 8, 2016 after fleeing from a domestic violence situation. For the past four years, Jane has lived in inpatient psychiatric hospitals, on the street, crisis residential facilities, LAHSA cold/wet weather shelters, and a garage. We recently met and reviewed her psychiatric treatment history and compiled the following list of dates and locations of Jane's living arrangements. Because of the client's cognitive deficits and memory loss, the following represents the best history this client can recollect:

01/08/2017 to 02/07/2017:	1736 Crisis House, Torrance, CA 90000
02/08/2017 to 03/15/2017:	New Image Emergency Shelter, Los Angeles, CA 90000
03/16/2017 to 06/31/2017:	Shady Lady Motel, 3434 Sunset Blvd., Hollywood, CA 90000
07/01/2017 to 08/31/2017:	Client does not remember where she resided
09/01/2017 to 10/25/2017:	Twin Towers Correctional Facility
10/26/2017 to 12/15/2017:	"Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
12/16/2017 to 12/19/2017:	BHC Hospital, Psychiatric Unit, Rosemead, CA 90000
12/20/2017 to 01/19/2018:	Excelsior House Crisis Residential Treatment, LA, CA 90000
01/20/2018 to 04/01/2018:	"Streets" – Car parked at 1720 E 120th St., Los Angeles, CA 90000 (Car was towed)
04/02/2018 to 04/15/2018:	"Streets" – Alley between Augustus Hawkins MHC and King Drew Medical Center, Los Angeles, CA 90000
04/16/2018 to 06/20/2018:	Help is on the Way Shelter, Los Angeles, CA 90000
06/21/2018 to 07/26/2018:	Client does not remember where she resided

DEPARTMENT OF MENTAL HEALTH

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JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

07/27/2018 to 08/05/2018:	Brotman Medical Center, Psychiatric Unit, LA, CA 90000
08/06/2018 to 12/15/2018:	"Streets" – 2nd and Broadway, Santa Monica, CA 90000
12/16/2018 to 03/15/2019:	New Directions Emergency Shelter, West LA, CA 90000
03/16/2019 to 04/10/2019:	Weingart Center Shelter, Los Angeles, CA 90000
04/11/2019 to 08/04/2019:	"Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
08/05/2019 to 08/08/2019:	Robert F. Kennedy, Psychiatric Unit, Los Angeles, CA 90000
08/09/2019 to 02/09/2020:	Daybreak Transitional Living Program, SM, CA 90000
02/10/2020 to 05/06/2020:	Garage/Abandoned Home -- 1796 Raymond St., Los Angeles, CA 90000. The garage lacked cooking facilities, a restroom or shower, running water, electricity, and insulation to keep warm. The roof often leaked when it rains.
05/07/2020 to 05/22/2020:	Twin Towers Correctional Facility – Arrested for trespassing
05/23/2020 to 06/15/2020:	"Streets" – near Cherokee and Hollywood Blvd., Hollywood, CA 90000
06/15/2020 to 09/15/2020:	Jan Clayton Center Residential Substance Abuse Treatment, Hollywood, CA 90000
09/16/2020 to present:	PATH Specialized Shelter Bed Program, LA, CA 90000

Jane is an appropriate candidate for the Continuum of Care program because she is now medication compliant, has completed courses in parenting, independent living skills, and money management. In the past, Jane successfully maintained a residence and has good independent living skills. Jane is a part of the Money Management Program at Hollywood Mental Health Center, which will also continue to provide the intensive case management that will allow her to maintain independence in the community. In addition, Jane has completed a 90-day residential substance abuse treatment program and continues to maintain a relationship to her facility by attending outpatient groups. Jane also attends 12 Step groups for support and fellowship in recovery.

Jane has an 8-year-old daughter (Sheila Doe) who will live with her mother once she is in a stable living situation. Presently, Sheila resides with client's mother (Marie Doe) at 6703 67th Street, Lops Angeles. A letter from client's DCFS social worker indicating the child's current location and the social worker's intent to place the child with client at her new residence is attached.

I appreciate your time in reviewing this case. A Continuum of Care certificate would provide an avenue of stability for Jane. If you have any questions or concerns, please feel free to call me at 213-637-5555.

Sincerely,
Daisy Obetsanov, MSW
Psychiatric Social Worker

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

SPECIAL PROGRAM ADMINISTRATION

CONTINUUM OF CARE PROGRAM

Application Coversheet and Checklist Transmittal Form

(Please check off all boxes to ensure a complete application and reduce delays to the applicant.)

Client Name: _____

The following forms are required for every applicant under the **Continuum of Care** program. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, please fill in all forms thoroughly. Place a check mark next to the document included in this application packet and stack forms in the following order:

Required Application Forms

- ☐ Referral Transmittal Form (CoC-RT)
- ☐ Coordinated Entry System (CES) Referral Form (CoC CES)
- ☐ DHS/DMH Referral Form [CoC DHS-DMH]
- ☐ Housing Authority Special Programs Application for Rental Assistance [Joint Application Rev 11/15]
- ☐ Authorization for Release of Information [Joint Application]
- ☐ Authorization to Release Information [Joint Application]
- ☐ Authorization for the Release of Information/Privacy Act Notice (HUD 9886)
- ☐ Declaration of Citizenship / Eligible Immigration Status (NC 100)
- ☐ Certification of No Conflict of Interest (CoC 1)
- ☐ Limited English Proficiency Notice - Rental Assistance (LEP 02 RA)
- ☐ Continuum of Care Project/Sponsor-Based Family Obligations (HAPP 149 PSB CoC)
- ☐ Continuum of Care Tenant-Based Family Obligations (HAPP 149 CoC)
- ☐ Certified Statement [Yes/No Questions](ANC 19)
- ☐ Authorization for Release of Confidential DPSS Information (RE DPSS)
- ☐ Verification of Department of Public Social Services Assistance (RE 29)
- ☐ CalWORKS Homelessness Certification (ANC-CW-1)
- ☐ Reasonable Accommodation Questionnaire (S504 02)
- ☐ Third-Party Verification of Homeless Status (LAHSA 1444)
- ☐ Observation of Homeless Status (LAHSA 2199)
- ☐ Self Certification of Homeless Status (LAHSA 1448)
- ☐ Verification of Disability (LAHSA 2833)
- ☐ Dedicated Plus Verification (LAHSA 2835)
- ☐ Statement of Family Responsibility Supportive Services (Special Programs-Supp)
- ☐ Disclosure of Information on Lead-Based Paint (HAPP RLA 12) [PBRA/SBRA Only]

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

SPECIAL PROGRAM ADMINISTRATION

CONTINUUM OF CARE PROGRAM

Application Coversheet and Checklist Transmittal Form

(Please check off all boxes to ensure a complete application and reduce delays to the applicant)

Income and Asset Documentation

For **ALL** family members, please provide the following documents to which they apply.

- ☐ Employment Income
  - ○ 2 most recent consecutive check stubs
- ☐ Current verification of AFDC/Cal Works and/or General Relief/CAPI
- ☐ Current verification of Social Security/Supplemental Security Income
- ☐ Current verification of Pension/Annuity
- ☐ Unemployment/State Disability Insurance
  - ○ Current Award Letter, **OR**
  - ○ 2 most recent consecutive check stubs
- ☐ Child Support
  - ○ Payment History Chart, **OR**
  - ○ 2 most recent consecutive check stubs
- ☐ Adoption/Foster Care/Kin-Gap
  - ○ Assistance Payment Letter **OR**
  - ○ 2 most recent consecutive check stubs
- ☐ Self Employed/Own Business
  - ○ All pages of most recent tax return, **AND**
  - ○ W2's & 1099's
- ☐ Most recent statement for all bank accounts (all pages)
- ☐ Life Insurance
  - ○ All pages of each policy

Identification Documents

- ☐ Valid Government Issued Identification (All Adults 18 & over)
- ☐ Permanent Residence Card (If Applicable)
- ☐ Social Security Card (All Members of Household)
- ☐ Birth Certificates (All Minors)

Client Name: _____ Date: _____

SSN: _____

Submitted by: _____ Agency: DMH /

Phone #: _____ Email: _____

Sponsors are required per HUD to keep a copy of all paperwork and forms submitted to HACLA.
Copy of completed application made prior to submission..... ☐

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

CONTINUUM OF CARE

REFERRAL TRANSMITTAL FORM

(This form must accompany every application submitted. Please retain a copy.)

TO: Housing Authority of the City of Los Angeles
SPA Department
2600 Wilshire Blvd, 2nd Floor
Los Angeles, CA 90057

FROM: DMH /
(REFERRING AGENCY NAME ONLY)

SUBJECT: REFERRALS SUBMITTED FOR APPROVAL

DATE: _____

The following referral is being submitted for approval for the LA Continuum of Care

Program HA Contract No. (If applicable)_____

HOUSING TYPE:

☐ Tenant Based ☐ Sponsor Based ☐ Project Based ☐ Expansion Unit

BED SIZE: **SRO** ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐

Unit Name & Address (If Applicable):

_____

_____

CLIENT'S NAME: _____

SSN: _____ SEX: _____ DOB: _____

CES/HMIS #_____

Certification to be completed by the Referring Agency/NPO

This Referral has been reviewed and approved by:

Tuwasha Plair-Fields
Name of Authorized Representative (NPO)

213-943-8490
Telephone Number

_____
Signature

tplair@dmh.lacounty.gov
Email

_____
Date

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

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CES REFERRAL FORM

This referral MUST be completed by your SPA's Coordinated Entry System (CES) Community Coordinator or Community Matcher.

CLIENT NAME: _____

CES/HMIS ID: _____ DOB: _____ SPA: _____

REFERRING AGENCY NAME: _____

AGENCY CONTACT: _____

AGENCY ADDRESS: _____

City / State / Zip: _____

AGENCY PHONE: _____

_____

AGENCY CONTACT SIGNATURE

_____

DATE

Please attach agency stamp or business card of Agency Contact completing this form in the box below:

Attach agency stamp or business card:

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To Obtain a CES Referral Form:

- Send an email to the CES Matcher in the SPA where client was matched and provide the following information:
  - Purpose of email/request
    - It is highly recommended that the subject line of your email should be “Request for CES Referral Form”
  - Client’s HMIS ID#

For a current list of the CES Leads and Matchers in your SPA, please visit:

https://www.lahsa.org/documents?id=2941-countywide-ces-matcher-list.pdf

PLACE HERE

HOUSING AUTHORITY SPECIAL PROGRAMS APPLICATION FOR RENTAL ASSISTANCE (11pgs)

To get a copy of this form, please refer to the email you received from the DMH/Federal Housing Subsidies Unit (FHSU) staff indicating that your client was approved to complete a housing application.

For any questions, you may contact:

FHSU@dmh.lacounty.gov

Applicant ID: _____

HOUSING AUTHORITY

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 1 of 2)

INSTRUCTIONS: EACH MEMBER OF THE HOUSEHOLD WHO IS 18 YEARS OF AGE OR OLDER MUST SIGN ON THE FOLLOWING PAGE

The undersign(s) do hereby authorize any agency, office, group, organization, business firm, financial institution, public or private school, or governmental entity, to release to the Housing Authority, any information or materials which the Housing Authority deems necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Certificate Program, Housing Voucher Program, Low Income Housing Programs, or any other housing program that the Housing Authority may administer.

The information needed may include, but is not limited to: verification or inquiries regarding my identity, household members (including minors in my household), employment, income, financial accounts, assets, school records, allowances or preferences I have claimed, and residency.

The entities from which the Housing Authority may request information shall include, but are not limited to: financial institutions (42 U.S.C. Sec 3544); social service agencies; educational institutions; welfare agencies; Veteran's Administration; court clerks; utility companies; workmen's compensation payers; public and private retirement systems; law enforcement agencies; credit providers; postal service; and unemployment insurance agencies.

Records from financial institutions shall include all credit card account statements, loan account statements, mortgage account statements, loan applications, credit applications and any and all other account statements.

It is understood and agreed that this authorization or the information obtained with its use may be given to and used by the Housing Authority in the administration and enforcement of program rules and regulations and that the Housing Authority may in the course of its duties obtain such information from other Federal, State, or local agencies including State Employment Security Agencies; Department of Defense; Office of Personnel Management; the Social Security Administration; and welfare and food stamp agencies.

I understand and agree that a photocopy of this authorization may be used for the purposes stated above. This authorization for release of information expires fifteen months from the date signed.

(Signatures and family information required on following page)

Applicant ID: _____

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 2 of 2)

(This consent form expires 15 months from the date signed)

Instructions: Provide information requested below for all household members.

Printed Name (Head of Household)		Social Security Number
Address	City	State Zip
Telephone Number		Date of Birth

Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending

INSTRUCTIONS: All members of the household 18 years of age and older must sign below.

Signature – Head of Household	Date
Signature – Other Adult	Date
Signature – Other Adult	Date
Signature – Other Adult	Date

Housing Authority

Authorization to Release Information

EID#:_____

I authorize the Housing Authority to release any requested information, to provide copies of any documents contained in my file, and to discuss any topic relevant to my application for or participation in a Housing Authority assisted program with the following and their agents or employees:

☐ Legal Aid Foundation or Neighborhood Legal Services

Attorney's Name: _____

☐ My congressperson or local elected representative

Representative's Name: _____

☐ My case manager from an agency providing supportive services

Name of Agency: _____

☑ Other (please name): Los Angeles County Department of Mental Health

Client's Name: _____

Signature: _____ Date: _____

Releasing Information to the Media:

The Housing Authority does not release information to the media (television, radio, newspapers, etc.) except as authorized by its Community Relations Division. This form cannot be used to authorize release of any information to the media other than a specific media ombudsperson indicated above.

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Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

OMB CONTROL NUMBER: 2501-0014

exp. 07/31/2021

PHA requesting release of information; **(Cross out space if none)** (Full address, name of contact person, and date)	IHA requesting release of information: **(Cross out space if none)** (Full address, name of contact person, and date)
Housing Authority of the City of Los Angeles 2600 Wilshire Blvd. Los Angeles, CA 90057	

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

Client No:

HOUSING AUTHORITY

DECLARATION OF CITIZENSHIP/ELIGIBLE IMMIGRATION STATUS

INSTRUCTIONS: In order to be eligible to receive housing assistance, each resident/program applicant must be within the United States lawfully. Please read the certification carefully and return it as directed. Each family member who is age 18 or older must sign a Certification form. The responsible adult who will be living in the unit must sign the Certification form for all family members under the age of 18.

I CERTIFY THAT, under the penalty of perjury, to the best of my knowledge, I am lawfully within the United States because (please check the appropriate boxes):

A. ☐ I am a citizen, naturalized citizen, or a national of the United States.
B. ☐ I have eligible immigration status.
Alien Registration No. _____

I CERTIFY THAT:

C. ☐ I do not have eligible immigration status.
D. ☐ I choose not to state my immigrant status.
E. ☐ I am signing the Certification on behalf of minors(s):

Minor's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)	Alien Registration
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ I am signing the certification on behalf of adult family member(s) who do not have eligible immigration status or do not choose to state their immigration status *(head of household or spouse must be a citizen or have eligible immigration status to certify under this category):*

Family Member's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)
			C D
			C D
			C D

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLFULLY MAKING FALSE OR FRAUDULENT STATEMENTS OR REPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES. IN ADDITION, MAKING FALSE STATEMENTS IS A FELONY UNDER CALIFORNIA STATE LAW (PENAL CODE SECTIONS:115, 118, 487 AND 532) AND MAY RESULT IN CRIMINAL CHARGES INCLUDING BUT NOT LIMITED TO: PERJURY, GRAND THEFT, FILING FALSE DOCUMENTS WITH A PUBLIC OFFICE AND OBTAINING MONEY UNDER FALSE PRETENSES.

SECTION 487i OF THE CALIFORNIA PENAL CODE STATES THAT ANY PERSON WHO DEFRAUDS A HOUSING PROGRAM OF A PUBLIC HOUSING AUTHORITY OF MORE THAN FOUR HUNDRED DOLLARS ($400) IS GUILTY OF GRAND THEFT.

_____ _____ _____

Print Name Signature Date

Client No:

AUTORIDAD DE VIVIENDA

DECLARACIÓN DE CIUDADANÍA/ESTADO INMIGRATORIO ELEGIBLE

INSTRUCCIONES: A fin de reunir los requisitos legales para continuar recibiendo asistencia de vivienda, cada residente o participante del programa debe radicar en los Estados Unidos legalmente. Favor de leer la certificación cuidadosamente y devuélvala como se indica. Todo miembro de la familia que sea mayor de 18 años de edad debe firmar un formulario de certificación. El adulto responsable que va a residir en la vivienda debe firmar el formulario de certificación por todos los miembros de la familia que sean menores de 18 años.

CERTIFICO QUE, bajo pena de perjurio y según mi leal saber y entender, radico legalmente en los Estados Unidos porque (favor de marcar las casillas pertinentes):

A. ☐ Soy ciudadano de los Estados Unidos, ciudadano naturalizado o por nacimiento.
B. ☐ Tengo un estado elegible de inmigración.
Número de cédula _____.

CERTIFICO QUE:

C. ☐ No tengo estado elegible de inmigración.
D. ☐ Opto por no declarar mi estado de inmigración.
E. ☐ Firmo la certificación por parte de un menor o menores:

Nombre del menor	Fecha de Nacimiento	Parentesco	Estado de ciudadanía (seleccione la letra que corresponde con la frase anterior)	Número de cédula
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ Firmo la certificación a nombre de miembros adultos de la familia que no tienen estado elegible de inmigración u optan por no declarar su estado de inmigración *(el jefe de familia o cónyuge debe ser ciudadano o tener estado elegible de inmigración para certificar en esta categoría)*:

Nombre del familiar	Fecha de nacimiento	Parentesco	Estado de inmigración (seleccione la letra que corresponde con la frase anterior)
			C D
			C D
			C D

ADVERTENCIA: EL TÍTULO 18, SECCIÓN 1001 DEL CÓDIGO DE LOS ESTADOS UNIDOS ESTABLECE QUE UNA PERSONA ES CULPABLE DE UN DELITO GRAVE SI A SABIENDAS Y POR VOLUNTAD PROPIA HACE DECLARACIONES FALSAS O FRAUDULENTAS A UN DEPARTAMENTO U OFICINA DE LOS ESTADOS UNIDOS. HACER DECLARACIONES FALSAS ES UN DELITO GRAVE BAJO LA LEY DEL ESTADO DE CALIFORNIA (CÓDIGO PENAL SECCIONES: 115, 118, 487 Y 532) Y PUEDE TRAER COMO CONSECUENCIA CARGOS PENALES, INCLUYENDO PERO NO LIMITADO A: PERJURIO, HURTO MAYOR, ENTREGAR DOCUMENTOS FALSOS A UNA OFICINA PÚBLICA Y OBTENER DINERO DE MANERA FRAUDULENTA.

EL ARTÍCULO 487i DEL CÓDIGO PENAL DEL ESTADO DE CALIFORNIA ESTABLECE QUE TODA PERSONA QUE DEFRAUDE A UN PROGRAMA DE UNA AUTORIDAD DE VIVIENDA POR MÁS DE CUATROCIENTOS DÓLARES ($400) ES CULPABLE DE ROBO MAYOR.

_____ _____ _____

Nombre en letra de molde Firma Fecha

HOUSING AUTHORITY

Client No:

CONSENT FORM TO VERIFY IMMIGRATION STATUS WITH THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)

CONSENT: I consent to allow the Housing Authority to request and to obtain information from the U.S. Citizenship and Immigration Services (USCIS) for the purpose of verifying my eligibility and level of benefits under the Housing Authority's assisted housing programs. I understand that the Housing Authority cannot use it to delay, deny, or terminate housing assistance because of the immigration status of a family member, except as provided in the Department of Housing and Urban Development (HUD) regulations. In addition, I understand I must be given an opportunity to contest the determination with the USCIS or the Housing Authority or both.

Signatures:

ADULT(S): AGE 18 OR OVER

Head of Household (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Spouse (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date

MINOR(S): UNDER AGE 18

Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date

Who Must Sign: In order to be eligible to receive housing assistance, each noncitizen adult or minor applying for, or currently receiving, housing assistance must be lawfully within the U.S. Please read the Verification Consent Form carefully and sign and return as directed. Please feel free to consult with an immigration lawyer or other immigration expert of your choosing.

Privacy Act Statement: The information on this form is being collected by Housing Authority to determine the applicant's or participant's eligibility for housing assistance. The Housing Authority may release this information, without responsibility for the further use or transmission of the evidence by the entity receiving it to: (1) HUD, as required by HUD; and (2) to the USCIS for purposes of verification of the Immigration status of each individual and not for any other purpose.

Penalties for misusing this Consent: HUD, the Housing Authority and any owner (or any employee of HUD, the Housing Authority or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected on the consent form is restricted to the purposes cited on the form. Any person who knowing or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or resident/program participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or resident/program participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the Housing Authority or the owner responsible for the unauthorized disclosure or improper use.

AUTORIDAD DE LA VIVIENDA

Client No:

FORMULARIO DE AUTORIZACIÓN PARA VERIFICAR EL ESTADO DE INMIGRACIÓN CON EL SERVICIO DE CIUDADANÍA E INMIGRACIÓN DE ESTADOS UNIDOS (USCIS, por sus siglas en inglés)

AUTORIZACIÓN: Le concedo permiso a la Autoridad de la Vivienda a que solicite información del Servicio de Ciudadanía e Inmigración de Estados Unidos (USCIS, por sus siglas en inglés) con el fin de verificar mi elegibilidad y nivel de beneficios dentro de los programas de viviendas subsidiadas de la Autoridad de Vivienda. Tengo entendido que la Autoridad de Vivienda no puede usar la información para demorar, negar o anular la asistencia de vivienda debido al estado de inmigración de uno de los miembros de la familia, salvo como está estipulado por los reglamentos del Departamento de Vivienda y Desarrollo Urbano (HUD). Además, tengo entendido que se me debe dar una oportunidad para impugnar la determinación con el USCIS o con la Autoridad de Vivienda, o ambas.

Firmas:

ADULTO(S): MAYORES DE 18 Años

Jefe de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Cónyuge (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha

MENORES DE EDAD: MENORES DE 18 Años

Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha

Quién debe firmar: Para ser elegible para la asistencia de vivienda, cada adulto o menor que no sea ciudadano y que esté solicitando o actualmente reciba asistencia de vivienda, debe estar legalmente en los Estados Unidos. Por favor lea cuidadosamente el formulario de autorización de verificación, fírmelo y devuélvalo como se indica. Por favor no dude en consultar a un abogado especializado en asuntos de inmigración u otro perito de inmigración de su elección.

Declaración de Ley de Confidencialidad: La información de este formulario la solicita la Autoridad de Vivienda para determinar la elegibilidad del solicitante o participante para la asistencia de vivienda. La Autoridad de Vivienda puede compartir esta información, sin responsabilidad del uso posterior o envío de evidencia por parte de la entidad que la reciba con: (1) HUD, como lo requiere HUD; y (2) el USCIS para fines de verificación del estado de inmigración de cada individuo y no para otros fines.

Penalidades por el uso inadecuado de esta autorización: HUD, la Autoridad de Vivienda y cualquier propietario (o cualquier empleado de HUD, de la Autoridad de Vivienda o del propietario) estará sujeto a penalidades por divulgaciones sin autorización o por usos inadecuados de la información, según el formulario de autorización.

El uso de la información contenida en este formulario de autorización está limitado a los fines estipulados en el mismo. Cualquier persona que a sabiendas y deliberadamente solicite, obtenga o divulgue cualquier dato usando falsos pretextos con respecto a un solicitante o residente/participante de programa, estará sujeto a un delito menor y será multado hasta $5000. Cualquier solicitante o residente/participante de programa que se vea afectado por la divulgación negligente de información, puede presentar una demanda por daños y solicitar otra compensación, según sea apropiado, en contra de HUD, la Autoridad de Vivienda o el propietario responsable por la divulgación sin autorización o el uso inadecuado de la misma.

Housing Authority of the City of Los Angeles

Certification of No Conflict of Interest

A. A covered person may not have any direct or indirect interest in the HAP contract or in any benefits or payments under the contract (including the interest of an immediate family member of such covered individual) while such person is a covered individual or during one year thereafter.

B. "Covered person" means a person or entity who is a member of any of the following classes:

(1) An employee, agent, consultant, officer, or elected or appointed official of the recipient or its subrecipients;

(2) A person who exercises or has exercised any functions or responsibilities with respect to activities assisted under the Continuum of Care Rental Assistance Program;

(3) A person who is in a position to participate in a decision-making process or gain inside information with regard to activities assisted under the Continuum of Care Rental Assistance Program; or

(4) A person who may obtain a financial interest or benefit from an assisted activity, have a financial interest in any contract, subcontract, or agreement with respect to an assisted activity, or have a financial interest in the proceeds derived from an assisted activity, either for him or herself or for those with whom he or she has immediate family or business ties, during his or her tenure or during the one-year period following his or her tenure.

C. The sponsor agency certifies and is responsible for assuring that no person or entity has or will have a prohibited interest, at execution of the HAP contract, or at any time during the HAP contract term.

D. If a prohibited interest occurs, the owner shall promptly and fully disclose such interest to the HACLA and HUD.

E. The conflict of interest prohibition under this section may be waived by the HUD field office for good cause.

SPONSOR CERTIFICATION

I/(we) certify, by my/(our) signature(s) below, that in accordance with the above description I am/(we are) not a "covered person(s)" as described above AND that I am/(we are) NOT an employee/(employees) of the Housing Authority of the City of Los Angeles.

Sponsor's Printed Name _____ Date _____

Sponsor's Signature_____ Date _____

Sponsor's Signature_____ Date _____

If unable to certify, please provide your name and explain why:

_____

_____

FAMILY CERTIFICATION

I/(we) certify, by my/(our) signature(s) below, that I am/(we are) not related to the Sponsor Agency.

Head of Household's Signature_____ Date _____

Co-head's Signature_____ Date _____

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

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HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

LIMITED ENGLISH PROFICIENCY NOTICE
RENTAL ASSISTANCE PROGRAMS

The Housing Authority of the City of Los Angeles is sensitive to the needs of individuals with Limited English Proficiency (LEP) and is committed to ensure equal access to its services.

If you are an individual with limited English skills and would like to communicate either orally or in writing in a language other than English, please indicate your language preference on the back of this notice and submit it to your HACLA worker.

NOTIFICACIÓN DE CAPACIDAD LIMITADA EN INGLÉS - ***Spanish***

La Autoridad de Vivienda de la Ciudad de Los Ángeles es sensible a las necesidades de las personas con Capacidad Limitada en Inglés (LEP, por sus siglas en inglés) y está comprometida a asegurar el acceso igualitario a sus servicios.

Si es una persona con habilidades limitadas en inglés y quisiera comunicarse verbalmente o por escrito en un idioma que no sea inglés, por favor, indique la preferencia de su idioma en el formulario en la parte trasera de esta notificación y preséntela a su empleado de la HACLA.

ՍԱՀՄԱՆԱՓԱԿ ԱՆԳԼԵՐԵՆԻ ԻՄԱՑՈՒԹՅԱՆ ԾԱՆՈՒՑԱԳԻՐ - ***Armenian***

Լոս Անջելես Քաղաքի Բնակարանվորման Իշխանությունը ըմբռնումով է մոտենում Սահմանափակ Անգլերենի Իմացության (LEP) տեր անձանց խնդիրներին և հանձն է առել երաշխավորել իր ծառայությունների հավասար մատչելիությունը:

Եթե դուք ունեք սահմանափակ անգլերենի ունակություններ և ցանկանում եք բանավոր կամ գրավոր հաղորդակցվել ոչ-անգլերեն լեզվով, խնդրում ենք այս ծանուցագրի հետևի էջին գտնվող ձևաթղթի վրա նշել ձեր լեզվական նախասիրությունը և ներկայացնել HACLA-ի ձեր ներկայացուցչին:

СООБЩЕНИЕ ДЛЯ ЛИЦ С ОГРАНИЧЕННЫМ УРОВНЕМ ВЛАДЕНИЯ АНГЛИЙСКИМ ЯЗЫКОМ – ***Russian***

Жилищное Управление Лос-Анджелеса (ЖУЛА) внимательно относится к нуждам лиц с ограниченным уровнем владения английским языком (ОУВА) и прилагает все усилия для обеспечения равной возможности получения информации о его услугах.

Если вы являетесь лицом с ограниченным уровнем владения английским языком и желаете общаться, устно или письменно, на другом (то есть не на английском) языке, просим сообщить о вашем предпочтении в отношении используемого языка вашему работнику ЖУЛА.

제한적 영어 사용자 통지문 – ***Korean***

로스앤젤레스 주택국(The Housing Authority of the City of Los Angeles)은 제한적 영어 사용자 (LEP)의 필요점을 잘 알고 있으며 주택국이 제공하는 서비스를 동일하게 이용할 수 있도록 최선의 노력을 다하고 있습니다.

제한적 영어 구사자로써 영어이외의 언어로 구두나 문서로 통신하고 싶으시면 HACLA 직원에게 원하는 언어를 말씀해 주십시오.

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

LIMITED ENGLISH PROFICIENCY NOTICE - RENTAL ASSISTANCE PROGRAMS

☐ I prefer **Oral** Communication in English	☐ I prefer **Written** Communication in English	**English**
☐ Prefiero comunicación **oral** en español	☐ Prefiero comunicación **escrita** en español	**Spanish**
☐ Ես նախընտրում եմ **Բանավոր** հաղորդակցությունը հայերենով	☐ Ես նախընտրում եմ **Գրավոր** հաղորդակցությունը հայերենով	**Armenian**
☐ Я предпочитаю **Устное** общение на русском языке	☐ Я предпочитаю **Письменное** общение на русском языке	**Russian**
☐한국어로 **구두** 통신을 하고 싶습니다	☐한국어로 **문서** 통신을 하고 싶습니다	**Korean**
☐Other _____	☐Other _____	

_____ Name

_____ Signature

_____ Date

HACLA USE ONLY

Cal/Mgr Code: _____ Client No.: _____

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

SHELTER PLUS CARE/CONTINUUM OF CARE
TENANT-BASED FAMILY OBLIGATIONS

When your unit is approved and the Housing Assistance Payments (HAP) contract is signed, your family must follow the rules listed below.

A. THE FAMILY MUST:

1. Provide CORRECT AND ACCURATE INFORMATION, including proof of CITIZENSHIP or eligible IMMIGRATION status, and records about your INCOME and the income of all family members living with you. You must report all income such as wages, unemployment benefits, child support, Social Security, SSI, pensions and all ASSETS such as bank accounts, stocks, bonds, property ownership, whether or not you have income from them. (Live-in aides are exempt from providing information regarding income)
2. Provide any INFORMATION that the Housing Authority or HUD tells you is needed for any reexamination of family income and composition. You and all adult family members must sign forms that allow us to verify income, asset and other information required by the Housing Authority. (Live-in aides are exempt from providing income information.)
3. Provide and verify SOCIAL SECURITY NUMBERS for all members of your family including live-in aide. This requirement does not apply to individuals who do not contend eligible immigration status.
4. Provide TRUE and COMPLETE information.
5. PAY gas, electric, water or any other utility bill for which you are responsible. PROVIDE and keep in repair any appliances such as a stove or refrigerator which the owner does not provide. REPAIR or pay for damage to the unit caused by any household member or guest. Pay your portion of the rent on time.
6. Allow the Housing Authority to INSPECT your unit at reasonable times after reasonable notice. We will inspect your unit at least once a year.
7. NOTIFY the Housing Authority and the owner IN WRITING BEFORE moving out of the unit, or ending the lease. You must get a new certificate before you can move with tenant based S+C/CoC. You must give at least a 30 day WRITTEN NOTICE if you plan to move from your unit.
8. Immediately give the Housing Authority a copy of any EVICTION NOTICE.
9. Use the S+C/CoC unit as a place to live and ALLOW ONLY THE PEOPLE AUTHORIZED BY THE HOUSING AUTHORITY TO LIVE THERE. The unit must be a family's only place of living.
10. Immediately TELL the Housing Authority of the birth, adoption or court-awarded custody of a child. You must ask for and get WRITTEN APPROVAL before any other person (including family members, foster children or live-in aides) can live with you.
11. Immediately NOTIFY the Housing Authority IN WRITING if someone moves out or no longer lives in the unit.
12. Give the Housing Authority any information needed to prove that you or other family members are living in the unit or have moved out of the unit. (You must NOTIFY the Housing Authority of any time that you are away from the unit or expect to be away for more than thirty days.)

B. THE FAMILY MUST NOT:

1. COMMIT any serious or repeated VIOLATION OF THE LEASE.
2. Use your unit as a place of business rather than as a place to live.
3. SIGN OVER the lease to someone else or GIVE the unit to someone else.
4. SUBLEASE or LEASE or charge someone else rent for the unit or a part of the unit.
5. BE AN OWNER of the unit you are living in (unless it is a mobile home) or have any interest in the unit.
6. Commit any FRAUD, bribery or any other corrupt or criminal act in connection with the program. Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.
7. GIVE THE LANDLORD any secret or "under-the-table" money or pay more rent than the Housing Authority allows. If a landlord asks you to pay extra rent, notify your Special Programs Advisor immediately.
8. USE DRUGS or take part in other DRUG-RELATED CRIMINAL ACTIVITY or in VIOLENT CRIMINAL ACTIVITY.
9. The family must not participate in any other criminal activity that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing in the area near your unit. This applies to your entire household, whether or not you personally take part in the activity or even know about it.
10. ABUSE ALCOHOL in a way that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing near your unit.
11. RECEIVE ANY OTHER HOUSING ASSISTANCE (SUBSIDY) either to live in YOUR UNIT or to LIVEELSEWHERE while you have S+C/CoC assistance with us.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

SHELTER PLUS CARE/CONTINUUM OF CARE
TENANT-BASED FAMILY OBLIGATIONS

C. GROUNDS FOR DENIAL OF ASSISTANCE

The Housing Authority may deny your S+C/CoC application for any of the following:

1. You do not meet the homeless/chronically homeless definition established by HUD;
2. You do not meet the disabled definition;
3. You are ineligible due to income;
4. You are ineligible due to U.S. citizenship or immigration status requirements;
5. You fail to provide true and complete information to HACLA;
6. You fail to provide information requested by HACLA necessary in the administration of the program;
7. You have engaged in or threatened abusive or violent behavior toward any HACLA employee;
8. You currently owe rent or other amounts to the HACLA or to any other Public Housing Agency (PHA) in connection with Section 8 or public housing assistance and refuse to enter into a repayment agreement for amounts owed;
9. You breached a previous repayment agreement and refuse HACLA's offer to enter into a new agreement to pay amounts owed to a PHA or amounts paid to an owner by a PHA.

D. GROUNDS FOR TERMINATION OF ASSISTANCE

The Housing Authority may terminate your S+C/CoC for any of the following:

1. If you and the members of your household do not follow the family obligations listed above.
2. If you or any member of your household becomes a register as a sex offender in any state while being assisted.
3. If you or any member of your household ever produces or manufactures methamphetamine on the premises of federally assisted housing.
4. If you or any member of your household currently uses illegal drugs, or has a pattern of illegal drug use that may threaten the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted or convicted for drug related criminal activity while being assisted.
5. If you or any member of your household abuses alcohol or has a pattern of alcohol abuse that threatens the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted for reasons related to alcohol abuse.
6. If you or any member of your household commits fraud, bribery or any other corrupt or criminal act in connection with any federal housing program.
7. If you or any household member owes rent or other amounts to any housing authority in connection with S+C/ CoC assistance or public housing assistance, or has not repaid a housing authority for money paid to an owner under a Housing Assistance Payments Contract for rent, damages to the unit or other amounts owed under the lease while being assisted.
8. If your family breaks a repayment agreement with this or any other housing authority to pay amounts you owe to the housing authority.
9. If you or any member of your household is abusive or violent or makes threats against any Housing Authority employee.
10. If you or any member of your family does not immediately give the Housing Authority a copy of any letter or notice from HUD that gives information about the amount of income you receive or about verifying family income.
11. If you do not move to another unit when the Housing Authority tells you that your family is too large for the S +C/CoC unit you are living in or that your family is too small for its unit in S+C/CoC program.
12. If you do not accept an offer of assistance with conditions (that provides assistance to some family members but forbids others to live in the unit), or if any adult member of your family does not sign the statement of assistance with conditions, or if you violate the conditions.

All members of your family 18 years of age or older must sign this form.

Signature	Date	Signature	Date
Signature	Date	Signature	Date

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

2600 Wilshire Blvd, 2nd Fl. - Los Angeles, California 90057

www.hacla.org (213) 252-2500 TTY (213) 252-2646

CERTIFIED STATEMENT

Knowing the penalty for making a false statement under the United States Criminal Code, I hereby certify that the following is a true statement.

My name is _____

My Social Security number is _____

I live at _____

Write **YES** or **NO** to each of the statements as they apply to you.

1. I am working at the present time. _____
2. I have worked in the past 12 months. _____
3. I am self-employed (including babysitting, laborer, sales). _____
4. I attend high school, trade school or college. _____
5. I receive public assistance (TANF, CalWorks, CAPI, General Relief and/or Food Stamps). _____
6. I receive unemployment or disability benefits. _____
7. I receive contributions or child support. _____
8. I receive SSI, Social Security, and/or Private Pension. _____
9. I have a bank account (savings and/or checking). _____
10. I receive income from assets (real estate, stocks, bonds). _____
11. I receive income from the Veterans Administration. _____

Additional comments or information _____

_____

Signature _____ Date _____

Warning: Section 35A of the United States Criminal Code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine, or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction.

Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.

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Cal/Manager Code	Client #	Household Last Name	Unit #

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DPSS INFORMATION

(This consent form expires 15 months from the date it is signed)

I understand that I have a right to the privacy of my personal information. I also understand that provisions of law protect my information and identity as an applicant or recipient of public assistance. I have been told that the Housing Authority of the City of Los Angeles ("Authority") wants to use my personal information to determine if I am eligible to receive housing services.

I understand that if I sign this form, the Los Angeles County Department of Public Social Services ("DPSS") will share the information they have about me and the minor children I am the legal guardian of, including whether I receive public assistance, the amount of any assistance, and any sanctions which may have been imposed against me. I understand that by signing this form, I am voluntarily authorizing DPSS, its agents and employees to share the information they have about me and the minor children I am the legal guardian of.

I acknowledge that before signing this form, I have carefully read and fully understand its terms. This authorization will expire 15 months from the date of my signing. I understand that my refusal to sign this form will not impact the services I currently receive or am eligible to receive through DPSS; however, refusal to sign may lead to termination of my housing assistance provided by the Housing Authority. I understand that I have the right to revoke this authorization at any time by saying so in writing.

I understand that the U.S. Department of Housing and Urban Development ("HUD") and Authority conduct computer matching programs to verify the information supplied on my application or recertification. I understand and agree that this authorization and the information obtained with its use will be used by HUD and/or Authority in the administration and enforcement of program rules and regulations.

I understand, agree, and consent that a photocopy of this authorization may be used for the purposes stated above.

First Name	Last Name	Date of Birth	SSN	Signature

(ALL ADULT HOUSEHOLD MEMBERS MUST SIGN THIS RELEASE FORM)

Clave de Cal/Administrador	# del Cliente	Apellido de la Familia	# de Unidad

AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ANGELES

AUTORIZACIÓN PARA REVELAR INFORMACIÓN CONFIDENCIAL DEL DPSS

(Este formulario de consentimiento caduca a los 15 meses a partir de la fecha en que se firma)

Entiendo que tengo derecho a la privacidad de mi información personal. También entiendo que disposiciones de la ley protegen mi información e identidad como solicitante o recipiente de asistencia pública. Se me ha dicho que la Autoridad de Vivienda de la Ciudad de Los Angeles ("Autoridad") quiere utilizar mi información personal para determinar si soy elegible para recibir servicios de vivienda.

Entiendo que si firmo este formulario, el Departamento de Servicios Sociales Públicos del Condado de Los Angeles ("DPSS") compartirá la información que tiene de mí y de los menores de quienes soy el(la) tutor(a) legal, incluyendo si recibo asistencia pública, la cantidad de cualquier subsidio, y cualesquier sanciones que se hayan impuesto en mi contra. Entiendo que por mi firma de este formulario, estoy autorizando voluntariamente al DPSS, sus agentes y empleados a compartir la información que tienen acerca de mí y de los menores de quienes soy el(la) tutor(a) legal.

Reconozco que antes de firmar este formulario, he leído con detenimiento y entiendo completamente sus términos. Esta autorización caducará a los 15 meses a partir de la fecha de mi firma. Entiendo que mi negativa de firmar este formulario no afectará los servicios que recibo actualmente o para los que soy elegible de recibir a través del DPSS; sin embargo, la negativa de firmar puede conllevar a la terminación de mi subsidio de vivienda proveído por la Autoridad de Vivienda. Entiendo que tengo el derecho de revocar esta autorización en cualquier momento diciéndolo así por escrito.

Entiendo que el Departamento de Vivienda y Desarrollo Urbano de EE.UU. ("HUD") y la Autoridad conducen programas de confirmación informática para verificar la información proporcionada en mi solicitud o una nueva certificación. Entiendo y acuerdo que esta autorización y la información obtenida con su utilización serán usadas por HUD y/o la Autoridad en la administración y cumplimiento de las reglas y reglamentos del programa.

Entiendo, acuerdo y doy mi consentimiento de que una fotocopia de esta autorización puede ser utilizada para los fines expresados anteriormente.

Primer Nombre	Apellido	Fecha de Nacimiento	SSN	Firma

(TODOS LOS ADULTOS DEL HOGAR DEBEN FIRMAR ESTE FORMULARIO DE REVELACIÓN)

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

VERIFICATION OF DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS) ASSISTANCE

To: Los Angeles County Department of Social Services (DPSS)

Cal/Mgr Code: _____

Client No.: _____

Name: _____ SSN: _____

Case Name if Different: _____ Number in Assisted Household : _____

Address: _____

Please provide the information requested below. I certify that this information will only be used for official Housing Authority business to determine the client's eligibility and rent. Please return this form to the Housing Authority (address below) in the enclosed self addressed envelope or fax to (___) _____
Do not return the form to the client. Thank you for your assistance.

_____	_____	(___)_____	_____	_____
Name HACLA employee	Title	Phone	Signature	Date

Return To:

Attn:

Client Certification: I hereby authorize DPSS to release the information requested below concerning my eligibility, the amount of benefits, and the reason for benefit reduction to the Housing Authority in writing, by telephone, or by computer matching. This authorization is valid for one year from the date below.

Signature: _____ Date: _____

TO BE COMPLETED BY DPSS EMPLOYEE (please do not use the check digit in the case number.)

A. DPSS Case #: ☐☐☐☐☐☐☐ -- ☐☐ **B**. Aid Type: _____

C. Date of most recent case opening: _____ **D**. Effective date of present grant: _____

E. Number of persons aided: _____ **F**. Number of persons in the home: _____

G. Maximum Allowable Grant: _____ **H**. Actual Grant: _____

I. Is the family receiving Food Stamps? **Yes** ☐ **No** ☐
If "yes," what is the cash value? $_____

J. Any special needs? **Yes** ☐ **No** ☐
If "yes," what is the purpose: _____ Amount: $ _____

K. REDUCTIONS IN BENEFITS:

1. Is there a current reduction in benefits due to fraud? **Yes** ☐ **No** ☐ When did it start? _____
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   During what months/years did the fraud occur? _____
   During that period, what was the monthly amount the client actually received? $_____

2. Is there a current reduction in benefits because:
   - The family failed to participate in an economic self-sufficiency program? **Yes** ☐ **No** ☐
   - The family failed to comply with a work activities requirement? **Yes** ☐ **No** ☐

   If "yes" to either, what is the amount of the reduction? $_____ When did it start? _____
   When is the reduction (sanction) expected to end? _____

3. Is there a current reduction in benefits due to reasons other than fraud or non-compliance? **Yes** ☐ **No** ☐
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   Please state the reason for the benefit reduction: _____

L. Additional income of the family (Wages, SSA/SSI, Child Support, Other):

Source	Amt	Source	Amt
_____	$_____	_____	$_____
_____	$_____	_____	$_____

M. If no longer assisted, what was the termination date? _____

N. Client address if different from above: _____

DPSS Employee Signature: _____ Date: _____

Please print name: _____ Phone: (___)_____

File #: _____ District: _____

DPSS STAMP HERE

Please sign, date, and return this form to the Housing Authority only. Do not take or mail this form to any other agency, entity, or persons (including the client whose information is requested).

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HACLA USE ONLY

Date stamp receipt or document date, name, and title if oral verification

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

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HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

CalWORKS HOMELESSNESS CERTIFICATION

To: Los Angeles County DPSS Office

Date _____

Cal/Manager Code _____

Client No./Entity ID No. _____

Return to: HACLA; 2600 Wilshire Blvd; Los Angeles, CA 90057

Attention: _____ Phone: _____ Email: _____

Please provide the information requested below. This information will only be used for official business between the Housing Authority of the City of Los Angeles (HACLA) and the Department of Public Social Services (DPSS) to determine eligibility for additional assistance through CalWORKS.

Name: _____ **SSN:** _____

Case name, if different: _____ **DOB:** _____

Address: _____

Check all statements that apply:

☐ I am currently a CalWORKS recipient.
☐ I currently reside in a shelter or transitional housing.
☐ I currently sleep in a public or private place not designed or ordinarily used for that purpose.
☐ I am currently in need of housing in a motel/hotel, shelter, or transitional housing.

Applicant Certification: I hereby certify that all the information above is true and correct to the best of my knowledge. With my signature, I also authorize the Housing Authority of the City of Los Angeles to release to the Department of Public Social Services in writing, by telephone or computer matching the requested information concerning my application. I understand that this authorization is valid for eighteen (18) months from the date below.

Signature _____ **Date** _____

DPSS STAMP HERE

Date: _____

DPSS Employee Name: _____

Employee Signature: _____

Telephone: _____

Email: _____

WARNING: 18 U.S.C 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

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HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

REASONABLE ACCOMMODATION QUESTIONNAIRE

A person with a disability(ies) may request a change, exception or adjustment to HACLA's rules, policies, practices, procedures or modifications to its housing units or common areas as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. **This form is to be completed and returned to the HACLA as part of the application and annual review process but can be requested and submitted at any time as needed.**
Contact your HACLA worker if assistance is needed in completing this form.

Head of Household Name: _____ Reg #/Client # _____

Address: _____ Phone # _____

Other preferred contact information: _____

Please check the appropriate box, provide the information as necessary, sign the bottom, and submit to the HACLA.

1. Does anyone in your household need a reasonable accommodation?

☐ No - If **No**, complete number 3 below

☐ Yes - If **Yes**, complete numbers 1a, 1b, 1c, 2, and 3 below

1a. Print the name of the family member requiring the accommodation _____

1b. Describe the accommodation needed _____

_____

_____

1c. Is this request to rescind a negative action taken by HACLA because the family did not comply with program requirements and the reason for not complying was due to a household member's disability? ☐ No ☐ Yes

If **Yes**, how did the disability prevent compliance with the rules and requirements of the program? *(Include any applicable dates)* _____

_____

_____

_____

2. Person who can verify the disability and the disability-related need for the accommodation, such as but not limited to: a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor.

Name: _____

Agency (if applicable): _____

Address: _____

Phone number: (____) _____ Fax number: (____) _____

E-mail (if known): _____

3. Signature: I certify the above information is correct.

_____ _____

Signature of Head of Household or Co-head Date

4. Please submit the completed form to the HACLA.

For HACLA use only

Received by: _____ Date _____

Notes:

Cal/Manager Code: _____
Unit No: _____
Reg./Client No: _____
Review Month: _____

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

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THIRD PARTY VERIFICATION OF HOMELESS STATUS FORM

Applicant Name (Head of Household): _____ **DOB:** _____

Household Size: _____ **Number of Adults:** _____ **Number of Minors:** _____

SECTION I: TO BE COMPLETED BY APPLICANT

Applicant Release Authorization:

I, _____, hereby authorize _____ to release information
(Applicant Name) **(Name of Organization)**

regarding my living situation. I understand this information is used for the purpose of determining homeless status.

Signature of Applicant: _____ **Date:** _____

SECTION II: INSTRUCTIONS

This form is intended to be used by agencies which can verify the status of a client as experiencing homelessness. This form can be used to track and certify the instance(s) that a client has sought the same services from a single agency. If checking the "Place Not Meant for Human Habitation" under HUD Category 1: Literally Homeless, please use the Observation of Homeless Status form. If checking HUD Category 4: Fleeing Domestic Violence, complete the second page.

SECTION III: TO BE COMPLETED BY AGENCY VERIFYING APPLICANT'S HOMELESS STATUS

☒ **HUD Category 1: Literally Homeless (If checking Category 1, check only one box below and complete fields below.)**

☐ **STOP – The Observation of Homeless Status Form must be used for any household living in a place not meant for human habitation. Please complete the Observation of Homeless Status form instead.**
~~**Place Not Meant for Human Habitation** A public or private place not meant for, or ordinarily used as a regular sleeping accommodation for human beings, including a street, sidewalk, car, park, abandoned building, bus station, airport, or camp ground~~.

☐ **Emergency Shelter** A supervised publicly or privately-owned emergency shelter designated to provide temporary living accommodations.

☐ **Hotel or Motel paid for by a Charitable Organization or Federal, State, and Local Government Program**

☐ **Exiting an Institutional Care facility** (i.e. jail, substance abuse treatment facility, mental health treatment facility, hospital, or other similar facility); stay must be 90 days or less AND had previously resided in a shelter or in a place not meant for human habitation before entering the institution.

☐ **Safe Haven** supportive housing serving hard-to-reach homeless persons with severe mental illness, usually coming from the streets.

☐ **Transitional Housing (<u>non-CoC programs only</u>)** a project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living.

Location/ Facility	Address of Location/ Facility	Time Period Being Verified		
		Start Date	End Date	# of Days
				0
				0
				0
			Total Days	0

Before coming to this location/facility, the applicant resided at/on/in _____

☒ **HUD Category 4: Fleeing Domestic Violence (If checking Category 4, check applicable boxes and complete the fields below.)**

☐ Fleeing or attempting to flee, domestic violence, dating violence, sexual assault, human trafficking, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member;

☐ I have no other residence; *and*

☐ I lack the resources or support networks to obtain permanent housing

Description of Situation (Include known dates of homelessness and length of stay if applicable).	**Time Period Being Verified**		
	Start Date	**End Date**	**# of Days**
			0
		Total Days	0

AGENCY/STAFF CERTIFICATION

I certify that, to the best of my knowledge and belief, all the information presented and attached to this form is true, accurate and complete.

Staff Name: _____ **Staff Title:** _____

Staff Email: _____ **Staff Signature:** _____

Agency Name: _____

Agency Address: _____

Service Planning Area: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 **Date Completed:** _____

Organizational Stamp/Card:

OBSERVATION OF HOMELESS STATUS FORM

Applicant Name (Head of Household): _____ **Date of Birth:** _____

Household Size: _____ **Number of Adults:** _____ **Number of Minors:** _____

SECTION I: INSTRUCTIONS: WHO FILLS OUT THIS FORM

An outreach worker, service provider, or other third-party source such as a community member or business owner may provide details of their contact with an individual or head of household in order to document that the individual or household is currently or has previously resided in a place not meant for human habitation (e.g. street, car, park, abandoned building, bus station, airport, campground). See page 2 for additional instruction on how to complete this form. Additional instructions are provided on Page 2.

SECTION II: TO BE COMPLETED BY OBSERVING PERSON

Current: To document where the individual or head of household is currently residing, the observing party must provide a date that is within 7 days of intake and the observation must have occurred at the location in which the individual or household is currently residing.

***Prior Occasion*:** To document where the individual or head of household has resided previously, the observing party may provide a description of any and all encounters that have occurred within the last 3 years. For each observation, please provide the date and a description of the location in which the encounter occurred (see Page 2 for additional instruction). Where the observing party encountered the individual or head of household on more than one occasion during a single month the observing party can provide a single description and provide the dates for each encounter in one row (i.e. 7/9; 7/17; 7/23).

Current or Prior Occasion	Description	Date(s)

OBSERVATION CERTIFICATION

An outreach worker, service provider, or other third-party source such as a community member or business owner may provide details of their contact with an individual or head of household in order to document that the individual or household is currently or has previously resided in a place not meant for human habitation (e.g. street, car, park, abandoned building, bus station, airport, campground).

I certify that the person(s) named above is/are currently or has previously resided in a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for human beings such as on the streets or in a car, park, abandoned building, bus station, airport, campground.

☐ **Intake Staff** ☐ **Outreach Worker** ☐ **Case Manager** ☐ **Other:** Please Specify: _____

Agency Name (If Applicable): _____

Name of person providing statement/ observation: _____

Address: _____

E-Mail: _____ **Phone:** _____

Signature: _____ **Date**: _____

OBSERVATION OF HOMELESS STATUS FORM INSTRUCTIONS

The *Observation of Homeless Status Form* is to be used to provide third-party documentation verifying current or prior occasions in which an individual or head of household is or was residing in a place not meant for human habitation.

Who can provide third-party verification?

Any person that has observed the individual or head of household residing in a place not meant for human habitation may complete this form for current and/or prior occasions of homelessness. This includes persons who have made the observation in either a personal (community member or business/property owner, regardless of relationship) or professional capacity (including, but not limited to, an outreach worker, service provider, law enforcement officer, or healthcare provider who encountered the individual or head of household while working).

What qualifies as an acceptable observation?

Current observation of homelessness – If verifying that the individual or head of household is currently residing in a place not meant for human habitation, the encounter must have occurred in the physical location in which the individual or head of household is currently residing.

Prior observation of homelessness – If verifying prior occasions in which the individual or head of household has resided in a place not meant for human habitation the encounter may have occurred either in the physical location in which the individual or head of household is currently residing or in another location, depending on the nature of the encounter with the third-party source.

- ***Outreach worker/professional contact*** – An outreach worker or other person within the community who has encountered the individual or head of household in a professional capacity (i.e. healthcare professional, member of law enforcement) may document an encounter that occurred *either* in the location where the individual or head of household was residing or in another location. Where the encounter occurred in another location, the observing party must include in the description the reason in which they believe, to the best of their knowledge and professional judgement, that the individual or head of household was residing in a place not meant for human habitation at the time in which the encounter took place.

- ***Community member*** – A community member (i.e. neighborhood resident, business or property owner, etc.) may document prior occasions of homelessness provided that the encounter occurred in the place not meant for human habitation where the individual or head of household was residing at the time.

Additional guidance can be found at:

- https://www.hudexchange.info/faqs/2759/can-a-community-member-such-as-a-shopkeeper-or-neighborhood-resident/
- https://www.hudexchange.info/faqs/2760/can-housing-or-service-providers-such-as-emergency-shelter-staff-members/

SELF CERTIFICATION OF HOMELESS STATUS FORM

Applicant Name (Head of Household): _____ **Date of Birth:** _____

Household Size: _____ **Number of Adults:** _____ **Number of Minors:** _____

SECTION I: TO BE COMPLETED BY THE APPLICANT

☐ **HUD Category 1: Literally Homeless (If checking Category 1, check only one box below and complete fields below.)**

☐ **Place Not Meant for Human Habitation** A public or private place not meant for, or ordinarily used as a regular sleeping accommodation for human beings, including a street, sidewalk, car, park, abandoned building, bus station, airport, or camp ground.

☐ **Emergency Shelter** A supervised publicly or privately-owned emergency shelter designated to provide temporary living accommodations.

☐ **Hotel or Motel paid for by Charitable Organization or Federal, State, and Local Government Program**

☐ **Exiting an Institutional Care facility** (i.e. jail, substance abuse treatment facility, mental health treatment facility, hospital, or other similar facility); stay must be less than 90 days AND had previously resided in a shelter or in a place not meant for human habitation before entering the institution.

☐ **Safe Haven** supportive housing serving hard-to-reach homeless persons with severe mental illness, usually coming from the streets.

■ **Transitional Housing (non-CoC Programs only)** a project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living.

Location/ Facility	Address of Location/ Facility	Time Period Being Verified		
		Start Date	End Date	# of Days
				0
			Total Days	0

Before coming to this location/facility, the applicant resided at/on/in_____

☐ **HUD Category 4: Fleeing Domestic Violence (If checking Category 4, check applicable boxes and complete the fields below.)**

☐ I am fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, human trafficking, stalking or other dangerous or life-threatening conditions that relate to violence against myself or a family member; *and*

☐ I have no other residence; *and*

☐ I lack the resources or support networks to obtain permanent housing

Description of Situation (Include known dates of homelessness and length of stay if applicable):	Time Period Being Verified		
	Start Date	End Date	# of Days
			0
		Total Days	0

APPLICANT CERTIFICATION

I certify that, to the best of my knowledge and belief, all the information above and any other information I have provided in applying for homeless assistance is true, accurate and complete.

Applicant Printed Name: _____ **Applicant's Signature:** _____ **Date:** _____

AGENCY/STAFF CERTIFICATION

I understand that 3rd Party verification is the preferred method of certifying homelessness for an individual or family who is applying for assistance and self-declaration is only permitted when I have attempted but cannot obtain such verification.

Staff Name: _____ **Staff Title:** _____

Staff Email: _____ **Staff Signature:** _____

Agency Name: _____

Agency Address: _____

Service Planning Area: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 **Date Completed:** _____

Organizational Stamp/Card:

Applicant Name: ____________________ Date of Birth: ___________ HMIS ID: ___________

SECTION VI: DEDICATEDPLUS TIMELINE

Directions: Please complete the applicant's timeline below starting from the most current occasion of homelessness and work backwards in time. Check applicable boxes in each row to indicate the occasion or break, documentation method of verification and what documentation was attached to support the timeline. Once completed, add all occasions and months verified below to provide the total amount accounted for.

- See eligibility criteria on the instructions page for DedicatedPlus.

Occasion or Break	Start Date	End Date	# of Months Verified	Location (List street name/ park name, shelter name, encampment location, institution, etc. If other, please specify.)	Occasion of homelessness					Breaks in homelessness					Documentation Method of Verification						Documentation Attached
					Place not meant for human habitation	Emergency Shelter	Safe Haven	Hotel/Motel Paid by an Agency	Institution less than 90 days	Transitional Housing	Couch surfing	Paying for Hotel/Motel or other housing	Institution more than 90 days	Other	3rd Party- HMIS Record	3rd Party-Observation of Homeless Status	3rd Party- Verification of Homeless Status	3rd Party- Institutional Paperwork < 90	Agency Due Diligence to acquire 3rd	Self-Certification	
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
☐ Occasion ☐ Break					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No
# of Occasions:___			Total Months: ____	Verification of DedicatedPlus Status: ☐ CH; ☐ In Transitional Housing (TH) that is being eliminated & CH at TH entry; ☐ In Joint TH-RRH Project & CH at TH entrance; ☐ Currently homeless, was in PSH within last year, was unable to maintain housing, and was CH at time of entrance into PSH; ☐ Is homeless, in safe haven, or in emergency shelter for at least 12 months in the last three years but has not done so on four separate occasions; or ☐ Receiving assistance through a VA funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.																	

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VERIFICATION OF DISABILITY FORM
Continuum of Care Program

Date: _____

Dear Physician/ Qualified Health Personnel:

_____ has claimed eligibility for a federally funded housing program which requires a household
(Applicant Name)
member to have a qualifying disability. The claim must be certified by a professional licensed by the state to diagnose and treat the disability.

For the purpose of this program, an individual or qualifying household member must meet the definition of 'homeless individual with a disability' which can be found in Section 401 (9) of the McKinney-Vento Act, as amended by the HEARTH Act which is an individual who is homeless and has a disability that is expected to be long-continuing or of indefinite duration; substantially impedes the individual's ability to live independently; and, could be improved by the providing of more suitable housing conditions. The disability could be any physical, mental, or emotional impairment, including impairment caused by alcohol and/or drug abuse, post-traumatic stress disorder, or brain injury; a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency of acquired immunodeficiency syndrome.

Requested by: _____
(Name of Housing/ Service Provider)

SECTION TO BE COMPLETED BY APPLICANT:

Applicant's Release Authorization:

I, _____ **hereby authorize release of the information below:** _____ on _____.
(Applicant Name) **(Signature of Applicant)** **(Effective Date)**

MEDICAL CERTIFICATION
(SECTION TO BE COMPLETED BY LICENSED PROFESSIONAL)

As a professional licensed by the state to diagnose and treat this disability, it is my determination that the above applicant,

_____, **does have a disability as defined above as of** _____.
(Applicant Name) **(Date)**

Disability is: (Please check the box that applies).

- ☐ Physical Illness or Impairment
- ☐ Serious Mental Illness
- ☐ Substance Use Disorder
- ☐ AIDS or HIV Related Diseases
- ☐ Cognitive Impairments resulting from Brain Injury
- ☐ Post-Traumatic Stress Disorder
- ☐ Developmental Disability
- ☐ Other: _____

Additional information concerning this disability:

This disability: (Please check all the boxes that apply).

1) Is expected to be of long-continuing or of indefinite duration ☐ **YES** ☐ **NO**
2) Substantially impairs his/ her ability to live independently ☐ **YES** ☐ **NO**
3) Is of such nature that daily functioning and the disability could improve under more suitable housing conditions ☐ **YES** ☐ **NO**

Printed Name: _____ **License Number:** _____

Professional Title: _____ **Phone Number:** _____

Signature: _____ **Date:** _____

Name of Medical Group: _____

Agency Address: _____

Attach Organization Stamp/Card:

DEFINITION OF DISABILITY
COC PROGRAM

To be eligible for assistance under the CoC Program, an individual or family must meet the definition of homeless as set forth in section 578.3 of the CoC Program interim rule as well as any additional eligibility criteria set forth in the CoC Program NOFA under which the project was funded, which we have provided at the end of this response.

Where disability is an eligibility requirement for the project, the recipient must also document the program applicant's disability. As found in the HEARTH: Defining "Homeless" Final Rule, the following documentation of disability is accepted:

1. Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently; OR
2. Written verification from the Social Security Administration; OR
3. The receipt of a disability check; OR
4. Intake staff-recorded observation of a disability that, no later than 45 days of the application for assistance, is confirmed and accompanied by evidence in this; OR
5. Other documentation approved by HUD.

If the disability is not in the form of written verification from the Social Security Administration or in the form of a disability check, then the disability must be verified by a written diagnosis from a professional who is licensed by the state to diagnose and treat that condition. The recipient will need to determine whether the professional who plans to provide the written diagnosis meets HUD's requirement for their state.

Applicant Name: _____ **Date of Birth:** _____ **HMIS ID:** _____

SECTION VII: DISABILITY STATUS

A. Disability/ Disabilities (Check all that apply)

The head of household has been diagnosed by a licensed professional with one or more of the following:

- ☐ Chronic Physical illness or disability
- ☐ HIV/ AIDS
- ☐ Serious Mental illness
- ☐ Cognitive impairments resulting from brain injury
- ☐ Substance use disorder
- ☐ Post-traumatic stress disorder
- ☐ Alcohol Dependent
- ☐ Developmental disability
- ☐ Other: Please Specify: _____

B. Supporting Documentation: (Check the applicable box below)

Third Party documentation is required. Please indicate the type of verification supplied by checking off the box below and attach to the packet.

- ☐ Verification of Disability Form: Written verification of one or more disability by a professional licensed by the state to diagnose and treat the identified disability(ies) which certifies that the disability is expected to be of long-continuing or of indefinite duration; and, substantially impedes the individual's ability to live independently; and, could improve under more suitable housing conditions. OR
- ☐ Written verification from the Social Security Administration
- ☐ The receipt of a disability check (e.g. Social Security Disability Insurance check, Supplemental Security Income check or Veteran Disability Compensation).
- ☐ Intake staff-recorded observation of disability that dated within 45 days before Program Entry.

SECTION V: APPLICANT CERTIFICATION

To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ any changes in my housing status or address in writing during
(Name of Agency)
program participation and I understand that my application may be cancelled if I fail to do so.

_____	_____	_____
Head of Household's Printed Name	**Head of Household's Signature**	**Date**

SECTION VI: STAFF CERTIFICATION

To the best of my knowledge and ability, all of the information and documentation used in making this eligibility determination is true and complete.

Staff Name: _____ **Staff Phone Number:** _____

Staff Title: _____ **Staff Email:** _____

Agency Name: _____

Agency Address: _____

Service Planning Area: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Staff Signature: _____ **Date Completed:** _____

Applicant Name: _____ **Date of Birth:** _____ **HMIS ID:** _____

SECTION VIII. AGENCY DUE DILIGENCE TO ACQUIRE 3RD PARTY FORM

Every provider is required to do their due diligence in obtaining 3rd party verification of an applicant's homeless history to satisfy HUD's legal requirement for verification of a person's eligibility.

This document is intended to document and certify the provider's due diligence efforts.

By completing this form, the provider certifies they have taken the following steps to obtain third-party verification from _____and have the supporting in the file to support these efforts.

Description of Effort	Outcome of Effort, Including Obstacles	Documentation in File (Case Notes; Emails; Phone Logs; Returned Letters; Correspondences)	Date of Effort

SECTION V. STAFF CERTIFICATION

Staff Name:	**Staff Phone Number:**
Staff Title:	**Staff Email:**
Agency name:	**Agency Address:**
Staff Signature:	**Signature Date:**

Housing Authority of the City of Los Angeles

Continuum of Care

Statement of Family Responsibility (Supportive Services)

The Housing Authority of the City of Los Angeles has certified that the family headed by:

_____

is eligible to participate in the Continuum of Care Program.

Under this program the Housing Authority makes Housing Assistance Payments on behalf of the participants toward their rent to owners of decent, safe and sanitary housing units.

In addition to the requirements stated in the forms titled, ***Continuum of Care Family Obligations (HAPP-149 CoC)*** and ***Statement of Family Responsibility Project/Sponsor-Based Assistance Program (HAPP-149 PSB CoC)***, participants in the Continuum of Care Program are required to take part in the supportive services required by the following agency:

_____

Failure of the participant to abide by the Continuum of Care Family Obligations or to take part in the supportive services required by the above agency will be a basis for termination of rental assistance under the Continuum of Care Program.

The above agency is required to notify the Housing Authority of your failure to participate in the supportive services provided by the above agency under the Continuum of Care Program.

_____ _____

Participant's Signature Date

_____ _____

Agency Representative - Print Name and Title Representative's Phone Number

_____

Email

_____ _____

Agency Representative's Signature Date

CC: Agency/Applicant

HACLA makes Reasonable Accommodations for Persons with Disabilities
TDDs for the Hearing Impaired: (213) 252-2646; (213) 252-1639

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY – AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd. 2nd Fl. Los Angeles, CA 90057 (213)252-2500 TTY (213) 252-5313 www.hacla.org

OPTIONAL DESIGNATION OF AUTHORIZED REPRESENTATIVE/SIGNATORY

During the COVID-19 pandemic, as part of your homeless application, you can authorize a third-party representative and organization to act on your behalf to assist you with completing eligibility requirements for housing assistance. This authorization will help you with completing your application for housing assistance, which includes signing important documents on your behalf, resolving any issues that may arise during your eligibility process, and/or to assist you in providing any documents requested by the Housing Authority. You may update, remove, or change the information you provide on this form at any time. You are not required to provide this form, but if you choose to do so, please include the relevant information below.

Applicant Name:	
Mailing Address:	
Telephone No:	☐ Cell ☐ Other (specify) _____
Name of Authorized Representative:	
Organization:	
Address:	
Telephone No:	☐ Cell ☐ Other (specify) _____
E-Mail Address:	
Relationship to Applicant:	

I am authorizing the third party representative to: (Check all that apply)

☐ Complete and sign my application packet, which includes all forms provided by the Housing Authority

☐ Obtain and provide the Housing Authority any required documents to determine eligibility for housing assistance. Documents including, but not limited to, proper identification and/or Social Security Number verification. Attach documentation that authorized signatory has undertaken actions to obtain required documents, if available. **The family will be required to provide eligibility documents when received, within 90 calendar days of the effective date of the new admission, but no later than the first scheduled annual reexamination of income. If the family fails to meet the documentation submission requirements, the Housing Authority must terminate housing assistance**.

LEGAL DISCLOSURE AND AUTHORIZATION

This authorization will only be used during the COVID-19 pandemic to assist you with your homeless application and eligibility process. This authorization will be kept as part of your tenant file. You may update, remove, or change the information you provide on this form at any time during your application process. If issues arise during your application and eligibility process, the Housing Authority will contact the person or organization you listed as the authorized representative above. **By signing below, I declare under the penalty of perjury under the laws of the United States of America and State of California that the information provided above is true and correct.**

Signature of Applicant _____ **Date** _____

If applicant is not able to sign authorization, the authorized signatory must document how authorization was granted:

☐ Over the telephone (verbal statement from applicant). Date received: _____

☐ Email. Attach email communication

☐ Other communication. Attach supporting documents

Signature of Authorized Signatory _____ **Date** _____

Title 18, Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willfully making false or fraudulent statements or representations to any department or agency of the United States. In addition, making false statements is a felony under California State Law (Penal Code Sections: § 115, 118, 487 and 532 and Welfare Institution Code § 11054) and may result in criminal charges including but not limited to: perjury, grand theft, filing false documents with a public office and obtaining money under false pretenses

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www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is JOHN DOE

I live at Homeless on the streets on the corner of 1st St. and Main St. in Los Angeles, CA 99999

-OR- address of current residence

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
Section 35(A) of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF ANGELES in its capacity as a City, State, and Federal Agency.

Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

On this form, please have the applicant describe the following in his/her own words and writing:

1) if your case manager is unable to certify your homelessness on the street, you must self-certify the timeline and locations when you lived on the street, if applicable

2) explain how you became homeless

3) explain the reason that the address on your CA ID/DL is different from your current residence

4) explain the reason that the address on your Income Verification Letter is different from your current residence

5) explain the reason that the address on your Bank Statement is different from your current residence

6) if client does not have a bank account, explain how client receives payments

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

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www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is _____

I live at _____

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
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Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

_____

_____

_____

_____

_____

_____

_____

_____

_____

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

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DECLARACION CERTIFICADA

Nombre: _____

Domicilio:_____

ADVERTENCIA: El Título 18, Sección 1001 del Código de los Estados Unidos establece que una persona es culpable de un delito grave si a sabiendas y por voluntad propia hace declaraciones falsas o fraudulentas a un departamento u oficina de los Estados Unidos. Hacer declaraciones falsas es un delito grave bajo la ley del Estado de California (Código Penal Secciones: 115, 118, 487 y 532) y puede traer como consecuencia cargos penales, como perjurio, hurto mayor, entregar documentos falsos a una oficina pública y obtener dinero de manera fraudulenta.
La sección 35 (A) del Código penal de los Estados Unidos considera una ofensa criminal, con pena máxima de encarcelamiento por 10 años, multa de $10,000 dólares o ambos, el hacer una declaración falsa o representación a cualquier Departamento de los Estados Unidos en cualquier asunto dentro de su jurisdicción. La información proporcionada arriba fue solicitada por la AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ÁNGELES en su capacidad como una Ciudad, Estado, y Agencia Federal.

Conociendo la pena bajo el Código de Los Estados Unidos por hacer declaraciones falsas, por el presente doy fe que la siguiente es una declaración verdadera, cierta y completa:

_____

_____

_____

_____

_____

_____

_____

Esta declaración fue terminada, firmada y fechada con conocimiento, libremente, y voluntariamente, sin amenazas o la compulsión de cualquier persona para obtener mi declaración.

Firma _____ Fecha _____

Testimonio de _____ Fecha _____

PLACE HERE

INCOME VERIFICATION including the following:

- Verification of Employment and Earnings (3 months of pay stubs) (if applicable)
- Verification of DPSS Assistance (Notice of Action)
- Verification of Social Security Benefits
- Unemployment / State Disability Insurance Award Letter & 3 consecutive check stubs
- Child Support Payment History Chart & 3 consecutive check stubs
- Adoption / Foster Care / Kin-Gap Assistance Payment Letter
- Self-Employment – all pages of most recent year Tax Returns, W'2s & 1099s
- Bank Verification of Income and Assets (1 month bank statement) *for* ***every*** *household bank account*
- Verification of Contributions Received
- Retirement Income Verification Letter
- Life Insurance
- Pension / Annuity Award Letter

PLACE HERE

Copy of each household member's California Identification Card (ID) or Driver's License. **If the CA ID/DL expires before the client is housed, the application will be withdrawn;** therefore, if the ID/DL is within 6 months of expiration, ask the client to renew their ID at the DMV. Submit a copy of the DMV application/receipt with the HACLA application.

-and-

Copy of each household member's **signed** Social Security Card. If it is not signed, the application will be returned to the clinic/agency that submitted it.